TRAIN FOR SUCCESS INC.
SUPERVISORY POST BASIC COURSE
FOR LPN IN NURSING HOME FACILITIES 30Hr

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PURPOSE

The purpose of this course is to provide the licensed practical nurse (LPN) with a Board approved licensed practical nurse supervisory education course prior to accepting any supervisory position in the nursing home facilities. The course allows the licensed practical nurse to review the minimum thirty (30) hour post-basic licensed practical nurse supervisory education course which includes: Chapter 464, F.S., the Nurse Practice Act, Sections 456.031, 456.033, F.S., and Chapter 64B9, F.A.C., Rules and Regulations for Nursing, the scope of practice for the licensed practical nurse as defined in Section 464.003(3)(b), F.S., (c) The supervisory role of the licensed practical nurse as defined in Section 400.23(3)(c), F.S., including limits of authority and appropriate documentation in patient records, (d) Supervisory role transition, (e) Strategies for directing the practice of others, (f) Principles of delegation, (g) Effective communication, (h) Team building and conflict resolution, (i) Work performance accountability, (j) Employee evaluation, (k) Interpersonal relationship skills, (l) Assignment development, and (m) Recognition and resolution of inappropriate delegation.

The course provides the information that is required to be completed by the Florida Board of Nursing; thirty (30) hour supervisory post basic course for licensed practical nurse (LPN) in nursing home facilities; before accepting any supervisory position in the nursing home facilities.

OBJECTIVES

At the end of this course, the licensed practical nurse (LPN) /reader will be able to:

1. Describe strategies for directing the practice of others

2. Discuss the principles of delegation

3. Discuss the limits of authority

4. Discuss Florida laws and rules for nursing

5. Describe vital documentation and legal aspects in the nursing home environment

6. Apply principles of resident rights to nursing practice

7. Describe strategies for effective communication among patients and coworkers

8. Describe strategies for addressing /resolving inappropriate delegation

9. Discuss recognizing impairment in the workplace and the appropriate steps for reporting

10. Describe team building and conflict resolution

11. Discuss strategies for effective communication and interpersonal relationship skills

12. Describe assignment development and employee evaluation.

SUPERVISION

Supervision is the provision of guidance by a qualified nurse and periodic inspection by the nurse for the accomplishment of a nursing task or activity, provided the nurse is qualified and legally entitled to perform such task or activity. The supervisor may be the delegator or a person of equal or greater licensure to the delegator (64B9-14).

DELEGATION

PRINCIPLES OF DELEGATION

Delegation is defined as the assignment of authority or responsibility to another individual usually from a supervisor or manager to a subordinate, to carry out specific tasks or activities. All decisions that are related to delegation and assignments are based on the principles of protection of the health, safety, welfare and wellbeing of the patients, and the community /public.

NURSE PRACTICE ACTS

State nurse practice acts define the legal parameters for the nursing practice. Within most states the Registered Nurse is authorized to delegate.

Delegation is a professional right and responsibility.

Delegation involves both individual accountability as well as organizational accountability. Both the American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN) have developed resources to support the nurse in making decisions related to delegation.

Organizational accountability

Some of the organizational accountability for delegation relates to, making sure that sufficient resources are available such as:

Maintain documentation regarding the employee competency

Sufficient / appropriate staffing

Establish policies on delegation that are developed with the active participation of nurses

Making sure that the nurse has access to all competency information for the employee to whom the nurse will delegate care.

When delegating, the nurse should delegate only those tasks for which she or he believes the other health care worker has the skill and knowledge to perform, taking into consideration the training, experience, cultural competence the facility policies and procedure /agency policies and procedures.

NURSING EMPLOYERS / ORGANIZATIONS

Nursing employers / organizations need to keep in mind, that a licensed nurse, who has just received the license, is new/ a novice who will require some time to acquire foundational skills and knowledge. It takes time for an individual to develop delegation skills. Therefore employers need to create opportunities during employment orientation, inservices and staff development for training.

For the delegation process to be effective, the nurses will require confidence, knowledge, and skill. Also there will need to be ongoing opportunities to utilize the theory and also to apply the principles of delegation.

CHAPTER 64B9-14

DELEGATION TO UNLICENSED ASSISTIVE PERSONNEL

64B9-14.001 Definitions

64B9-14.002 Delegation of Tasks or Activities

64B9-14.003 Delegation of Tasks Prohibited

64B9-14.001 Definitions

As used in this chapter, the following mean:

(1) “Unlicensed assistive personnel” (UAP) are persons who do not hold licensure from the Division of Medical Quality Assurance of the Department of Health but who have been assigned to function in an assistive role to registered nurses or licensed practical nurses in the provision of patient care services through regular assignments or delegated tasks or activities and under the supervision of a nurse.

(2) “Assignments” are the normal daily functions of the UAP’s based on institutional or agency job duties which do not involve delegation of nursing functions or nursing judgment.

(3) “Competency” is the demonstrated ability to carry out specified tasks or activities with reasonable skill and safety that adheres to the prevailing standard of practice in the nursing community.

(4) “Validation” is ascertaining the competency including psychomotor skills of the UAP, verification of education or training of the UAP by the qualified individual delegating or supervising the task based on preestablished standards. Validation may be by direct verification of the delegator or assurance that the institution or agency has established and periodically reviews performance protocols, education or training for UAP’s.

(5) “Delegation” is the transference to a competent individual the authority to perform a selected task or activity in a selected situation by a nurse qualified by licensure and experience to perform the task or activity.

(6) “Delegator” is the registered nurse or licensed practical nurse delegating authority to the UAP.

(7) “Delegate” is the UAP receiving the authority from the delegator.

(8) “Supervision” is the provision of guidance by a qualified nurse and periodic inspection by the nurse for the accomplishment of a nursing task or activity, provided the nurse is qualified and legally entitled to perform such task or activity. The supervisor may be the delegator or a person of equal or greater licensure to the delegator.

(9) “Direct supervision” means the supervisor is on the premises but not necessarily immediately physically present where the tasks and activities are being performed.

(10) “Immediate supervision” means the supervisor is on the premises and is physically present where the task or activity is being performed.

(11) “Indirect supervision” means the supervisor is not on the premises but is accessible by two way communication, is able to respond to an inquiry when made, and is readily available for consultation.

(12) “Nursing judgment” is the intellectual process that a nurse exercises in forming an opinion and reaching a conclusion by analyzing data.

(13) “Education” means a degree or certification of the UAP in a specific practice area or activity providing background and experience in theoretical or clinical aspects of that practice or activity.

(14) “Training” is the learning of tasks by the UAP through on the job experience or instruction by a nurse who has the education or experience to perform the task or activity to be delegated.

64B9-14.002

DELEGATION OF TASKS OR ACTIVITIES

In the delegation process, the delegator must use nursing judgment to consider the suitability of the task or activity to be delegated.

(1) Factors to weigh in selecting the task or activity include:

(a) Potential for patient harm.

(b) complexity of the task.

(c) Predictability or unpredictability of outcome including the reasonable potential for a rapid change in the medical status of the patient.

(d) Level of interaction required or communication available with the patient.

(e) Resources both in equipment and personnel available in the patient setting.

(2) Factors to weigh in selecting and delegating to a specific delegate include:

(a) Normal assignments of the UAP.

(b) Validation or verification of the education and training of the delegate.

(3) The delegation process shall include communication to the UAP which identifies the task or activity, the expected or desired outcome, the limits of authority, the time frame for the delegation, the nature of the supervision required, verification of delegate’s understanding of assignment, verification of monitoring and supervision.

(4) Initial allocation of the task or activity to the delegate, periodic inspection of the accomplishment of such task or activity, and total nursing care responsibility remains with the qualified nurse delegating the tasks or assuming responsibility for supervision.

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64B9-14.003 DELEGATION OF TASKS PROHIBITED

The registered nurse or licensed practical nurse, under direction of the appropriate licensed professional as defined in Section 464.003(3)(b), F.S., shall not delegate:

(1) Those activities not within the delegating or supervising nurse's scope of practice.

(2) Nursing activities that include the use of the nursing process and require the special knowledge, nursing judgment or skills of a registered or practical nurse, including:

(a) The initial nursing assessment or any subsequent assessments;

(b) The determination of the nursing diagnosis or interpretations of nursing assessments;

(c) Establishment of the nursing care goals and development of the plan of care; and

(d) Evaluation of progress in relationship to the plan of care.

(3) Those activities for which the UAP has not demonstrated competence.

THE RIGHTS OF DELEGATION

The Five Rights of Delegation was developed by the National Council of State Boards of Nursing (NCSBN). The nurse needs to utilize professional judgment and critical thinking skills to follow the Rights of Delegation.

The Five Rights of Delegation; to make sure that the assignment or delegation is:

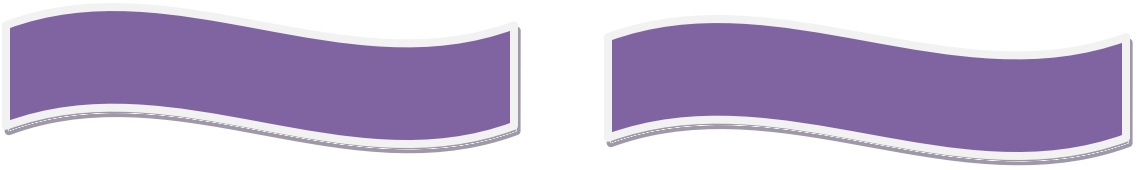
1.The right task

2. Under the right circumstances

3. To the right individual

4. With the right directions and communication

5. Under the right supervision and evaluation.



STEPS OF THE DELEGATION PROCESS:

PATIENT NEEDS AND RESOURSES AVAILABLE

It is recommended that the nurse assess then plan the delegation, based on the patients need and the availability of resources, the competence of the nursing team and the degree of supervision that will be required of the nurse if a task is delegated.

While delegating tasks to the delegate, the nurse is aware that communicating directions to the delegate includes communicating:

All unique patient characteristics and requirements

Clear expectations regarding what to do

Clear expectations regarding what to report

Clear expectations regarding when to ask for assistance.

SUPERVISION OF THE DELEGATION

Supervision of the delegation is required. The level of supervision that is needed for the particular task or situation has to be taken into consideration. The nurse needs to also make sure that there has to be follow up when problems arise or there is a change in situations.

EVALUATION

Evaluation is a necessary step, so that the nurse will be able to review the effectiveness of the delegation and review if there is a need to adjust the plan of care.

The nurse has to monitor for the effectiveness of delegation by reviewing questions such as:

Was the activity or task completed accurately?

Was the delegation effective or successful?

Was the outcome satisfactory?

Was the outcome unsatisfactory?

Was the outcome optimal?

Was the desired or expected outcome for the patient achieved?

Was the Nursing assistive personnel given the opportunity to ask questions?

Was the Nursing assistive personnel given the opportunity for clarifying expectations?

What were the challenges?

Was the communication timely?

Was the communication effective?

Does the plan of care require any adjustments?

If there were any problems, how were they addressed?

Is there a better way to meet the patients need?

Were there any teaching needs for the assistant or the nurse?

Was appropriate feedback given to the assistant regarding the performance of the delegation?

RECOGNITION AND RESOLUTION OF INAPPROPRIATE DELEGATION

The nurse is responsible for quick interventions and follow-up on concerns and /or problems or changing situations. When supervision and evaluation are completed, the nurse will be able to locate areas that need improvement, or need to be worked on, whether or not the assistant has difficulties completing the tasks or activities that were delegated.

When there is a need for resolution of inappropriate delegation, the nurse needs to be proactive to avoid any adverse effects to the patient involved. Therefore ongoing supervision has to be in place so that proper assessment and evaluations are completed which will allow the nurse to intervene as needed.

LIMITS OF AUTHORITY

CHAPTER 64B9-16

LPN SUPERVISION IN NURSING HOME FACILITIES

64B9-16.001 Definitions

64B9-16.002 Supervision by Licensed Practical Nurses in Nursing Home Facilities

64B9-16.003 Competency and Knowledge Requirements Necessary to Qualify the LPN to Supervise in Nursing Home Facilities

64B9-16.004 Delegation of Tasks Prohibited

64B9-16.001 DEFINITIONS

As used in this chapter, the following mean:

(1) “Certified nursing assistant” (CNA) is a person certified pursuant to Chapter 464, Part II, F.S.

(2) “Unlicensed personnel” (UP) are persons who do not hold licensure from the Division of Medical Quality Assurance of the Department of Health but who have been assigned to function in an assistive role to registered nurses or licensed practical nurses in the provision of patient care services through regular assignments or delegated tasks or activities and under the supervision of a nurse. Unlicensed personnel do not include certified nursing assistants.

(3) Nursing services are acts that require knowledge and skill based on biological, social, behavioral, and nursing science. Only specified nursing acts can be performed by CNAs and UPs. RNs and LPNs can perform nursing acts as stated in Section 464.003, F.S.

(4) “Supervision” is the provision of guidance and periodic inspection by the nurse for the accomplishment of a nursing task or activity, provided the nurse is qualified and legally entitled to perform such a task or activity. Supervision may be provided by an LPN to another LPN, CNA, or unlicensed personnel.

(5) “General supervision” means the registered nurse is not on the premises but accessible by two-way communication, is able to respond to an inquiry when made, and is readily available for consultation.

(6) “Immediate supervision” means the supervisor is on the premises and is physically present where the tasks and activities are being performed.

(7) “Indirect supervision” means the registered nurse is not on the premises but is accessible by two way communication, is able to respond to an inquiry when made, and is readily available for consultation.

(8) “Nursing home” means a facility licensed under Chapter 400, Part II, F.S.

(9) “Hospital” means a facility licensed pursuant to Chapter 395, F.S.

(10) “Delegation” is the transference to a competent individual the authority to perform a selected task or activity in a selected situation by a nurse qualified by licensure and experience to perform the task or activity.

64B9-16.002

Supervision by Licensed Practical Nurses in Nursing Home Facilities

(1) The licensed practical nurse working in a nursing home shall qualify to supervise by meeting all of the following requirements:

(a) Completing a minimum thirty (30) hour post-basic, Board approved licensed practical nurse supervisory education course prior to accepting any supervisory assignments. The course may be provided by a Board approved continuing education provider or an approved school of nursing.

(b) Demonstrating a work history of no less than six (6) months of full-time clinical nursing experience in a hospital or nursing home.

(2) In lieu of the thirty (30) hour post-basic nurse supervisory education course referenced above, licensed practical nurses may qualify to supervise if the nurse has successfully completed a supervisory course on a post-graduate level and a provider credits the nurse for such course, providing each component of the course content of paragraphs 64B9-15.003(3)(a)-(m), F.A.C., is tested by and competency demonstrated to the provider.

(3) There shall be a registered nurse providing supervision of the licensed practical nurse.

(4) Tasks and activities shall be delegated by the LPN to the CNA or UP based on the following:

(a) The task/activity is within the area of responsibility of the nurse delegating the task.

(b) The task/activity is within the knowledge, skills, and ability of the nurse delegating the task.

(c) The task/activity is of a routine, repetitive nature and shall not require the CNA or UP to exercise nursing knowledge, judgment, or skill.

(d) The CNA or UP can and will perform the task/activity with the degree of care and skill that would be expected of the nurse.

64B9-16.003

Competency and Knowledge Requirements Necessary to Qualify the LPN to Supervise in Nursing Home Facilities

(1) The licensed practical nurse supervisory course must be sponsored by an approved nursing education program or an approved provider of nursing continuing education pursuant to Chapter 64B9-5, F.A.C.

(2) The course instructor must be a currently licensed registered nurse in good standing with this state, have nursing education experience, and have professional nursing experience involving delegation and supervision.

(3) The minimum thirty (30) hour post-basic licensed practical nurse supervisory education course shall include:

(a) An overview of Chapter 464, F.S., the Nurse Practice Act, Sections 456.031, 456.033, F.S., and Chapter 64B9, F.A.C., Rules and Regulations for Nursing,

(b) The scope of practice for the licensed practical nurse is defined in Section 464.003(3)(b), F.S.,

(c) The supervisory role of the licensed practical nurse as defined in Section 400.23(3)(c), F.S., including limits of authority and appropriate documentation in patient records,

(d) Supervisory role transition,

(e) Strategies for directing the practice of others,

(f) Principles of delegation,

(g) Effective communication,

(h) Team building and conflict resolution,

(i) Work performance accountability,

(j) Employee evaluation,

(k) Interpersonal relationship skills,

(l) Assignment development, and

(m) Recognition and resolution of inappropriate delegation.

(4) Nursing homes utilizing licensed practical nurses in a supervisory role shall provide at least sixteen (16) hours supervisory experience with direct supervision by a registered nurse prior to the licensed practical nurse assuming supervisory responsibilities. Documentation by the registered nurse of the licensed practical nurse's supervisory competence shall be maintained in the licensed practical nurse's personnel file.

(5) Once a licensed practical nurse with at least five (5) years of full-time clinical nursing experience completes the sixteen (16) hours of supervisory experience as outlined above in (4), he or she may immediately begin supervisory duties and have until August 31, 2002, to complete the requirements outlined above in (1) and (2).

64B9-16.004 Delegation of Tasks Prohibited.

The licensed practical nurse, under the direction of the appropriate licensed professional as defined in Section 464.003(3)(b), F.S. shall not delegate:

(1) Any activity that is outside the scope of practice of the LPN; or in which the Nurse Practice Act stipulates that the LPN must have direct supervision of a Registered Nurse in order to perform the procedure.

(2) Those activities for which the licensed practical nurse, certified nursing assistant or UP has not demonstrated competence.

TEAM BUILDING & CONFLICT RESOLUTION

TEAM BUILDING

Some ways to form a collaborative work relationship and a strong and effective team with diverse members of the team is by:

Setting expectations

Providing guidance

Providing supervision

Defining their responsibilities

Communicating the expectations to each member of the team so they are aware of what they are accountable for.

Meeting regularly to keep the lines of communication open

Meeting as needed to address any team-building issues that exist.

Strengthening work relationships; staff appreciation group awards etc.

Meeting regularly to find out if they have any concerns or issues that needs to be addressed

Meeting regularly to assess their personal development

Meeting regularly to develop future goals.

CONFLICTS

TYPES OF CONFLICTS

- Intrapersonal conflict
- Interpersonal conflict,
- Intragroup conflict,
- Intergroup conflict.

Intrapersonal conflict

Intrapersonal conflict occurs within the individual (within the mind).

Interpersonal conflict

Refers to conflict which occurs between two people.

Intragroup conflict

Intragroup conflicts refers to conflicts that happens among individuals within the group

Intergroup conflict

Intergroup conflict refers to conflicts that take place among different teams within an organization.

CONFLICT RESOLUTION

5 STYLES OF MANAGING CONFLICT

A tool that has been developed is the Thomas-Kilmann Instrument (TKI).
TKI identifies 5 different styles that people frequently use when facing a conflict;

1. Accommodating with a goal to yield harmony and relationships.

2. Collaborating is the process of 2 or more individuals or organizations works together to realize mutual goals.

3. Compromising is defined as a settlement of differences by mutual concessions or an agreement reached by adjustment of conflicting

4. Avoiding conflicts – it is recommended that avoidance should only be used when the issue is not of great importance especially if the potential damage of having a confrontation outweighs the benefits.

5. Competing is often a negative way to manage conflict with a goal of winning wath ever the cost.

EMPLOYEE EVALUATION

A regular performance evaluation is an important step that helps you to monitor the performance of the staff.

To improve your employee evaluation skills:

Conduct employee evaluations on a regular basis.

Set reachable / reasonable yet specific goals.

Time frame – make sure that the employees know when you expect them to reach or attain their goals.

Employee evaluations should be given at least once a year.

Utilize objective criteria whenever possible.

Establish the evaluation criteria in advance and communicate the criteria with the employee (so that he/ she is aware).

Be specific and detail the reasons for giving the employee a particular performance rating. This will make it clear /easier to establish that the employee evaluation is correct.

Make sure that the evaluation is complete with details of the employee's strengths and weaknesses.

Identify ways to improve performance, this will assist the employee improve

Always be completely honest so that the employee will work on the areas that needs to be improved.

Effective Performance Evaluations

Supervisors need to evaluate the strengths and weaknesses of the staff. Criticism should be constructive and honest; this gives you the opportunity to point out the areas that need work and the opportunity to suggest ways or methods to improve performance.

Always give the employees the opportunity to read the evaluations. They should be given time to review it and make verbal and/ or written comments.

The supervisor who prepared the evaluation should be the one to present it to the employee.

The employee should sign the evaluation to acknowledge receipt of the evaluation.

There will be occasions where the employee may refuse to sign the evaluation. At this time the supervisor should document in the file that the employee was given the opportunity to read and review the evaluation, but did not sign it.

All evaluations should be kept in the employee's personnel file.

ASSIGNMENT DEVELOPMENT

According to the Agency For Health Care Administration (AHCA):

59A-4.108 Nursing Services

(1) The Administrator of each nursing home must designate one registered nurse as a Director of Nursing (DON) who shall be responsible and accountable for the supervision and administration of the total nursing services program. When a Director of Nursing is delegated institutional responsibilities, a full time qualified registered nurse (RN), as defined in Chapter 464, F.S., must be designated to serve as Assistant Director of Nursing. In a facility with a census of 121 or more residents, an RN must be designated as an Assistant Director of Nursing.

(2) Persons designated as Director of Nursing or Assistant Director of Nursing must

serve only one nursing home facility in this capacity, and shall not serve as the administrator of the nursing home facility.

(3) The Director of Nursing must designate one licensed nurse on each shift to be responsible for the delivery of nursing services during that shift.

(4) In accordance with the requirements outlined in subsection 400.23(3)(a), F.S., the nursing home licensee must have sufficient nursing staff, on a 24-hour basis to provide nursing and related services to residents in order to maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

(5) In multi-story, multi-wing, or multi-station nursing home facilities, there must be a minimum of one nursing services staff person who is capable of providing direct care on duty at all times on each floor, wing, or station.

(6) No nursing services staff person shall be scheduled for more than 16 hours within a 24 hour period, for three consecutive days, except in an emergency. Emergencies shall be documented and must be for a limited, specified period of time.

(7) Upon approval by the Agency, a nursing home licensee may allow a licensed nurse that performs both licensed nursing and certified nursing assistant duties during the same shift to divide the hours of patient care provided between the licensed nurse and certified nursing assistant staffing ratio requirements consistent with services provided, as referenced in Section 400.23(3)(a)4., F.S. Approval to utilize licensed nurses to perform certified nursing assistant duties must be requested in writing. This request may be submitted upon license renewal on the Health Care Licensing Application, Nursing Homes, AHCA Form 3110-6001, July 2014, incorporated by reference in paragraph 59A-4.103(1)(a), F.A.C. or by letter from the facility administrator. The Agency's approval depends upon review of the last three years' inspections from the date of the request to determine if there were deficiencies cited related to staffing.

The licensee must document daily the time the licensed nurse performed personal care services to comply with minimum staffing requirements. The hours of a licensed nurse with dual job responsibilities may not be counted twice.

RECOGNIZING IMPAIRMENT IN THE WORKPLACE

Substance abuse

Within the United States, the abuse of prescription drugs; especially the controlled substances, has become a very serious social and health issue. Anyone can become addicted to prescription medications. When the health care professionals; people in charge of the well being of others, have a problem with substance abuse, their lives as well as the patients in their care are at risk for harm. Many health care professionals have easy access to controlled substance medications; and some will divert and abuse these medications for various reasons such as relief from stress, or to self-medicate for some other reasons.

Medications that are frequently abused are classified into different categories such as:

Narcotics- Opiates for example hydrocodone, fentynal, oxycodone, hydromorphone,

Hypnotic anesthetics – Diprivan (Propofol)

Depressants - Barbiturates, Ethanol, Benzodiazipines

Hallucinogens - lysergic acid diethylamide (LSD), Ecstasy

Stimulants - Amphetamines, nicotine, cocaine

Inhalants – Toluene, Nitrous oxide

Cannabinoids - Marijuana .

Nursing - highly stressful occupation

Other risk factors for nurses in the workplace include:

- Easy access,
- Highly Stressful occupation,
- Attitude,
- Lack of education.

Medications are easily and readily available. Nurses/ practitioners are trained in the intravenous (IV) administration and injection of medications, have knowledge of frequency of administering medications which increases the risk for substance abuse.

The nursing occupation can be very stressful especially with;

- staffing shortages,
- increased acuteness,
- The work schedule
- shift rotation
- longer shifts,
- Patient ratios.

Healthcare practitioners are aware that long work hours often lead to;

- Fatigue,
- circadian rhythm disruption
- sleep deprivation,
- psychological consequences and
- Physiological effects.

Environmental factors, as well as gene, environment interactions and other factors account for the risk. ***However there are no good reasons for substance misuse.***

The Code of Ethics for Nurses

The Code of Ethics for Nurses was developed as a guide to carry out nursing responsibilities in a way that is consistent with quality in nursing care and the ethical obligations of the profession (ANA 2016).

RISK FACTORS

Some risk factors that tend to make individuals more susceptible to developing a substance use disorder are listed in the table below:

CATEGORIES	
Social factors	Access to the medication Availability of the medications Condone the use of drugs Condone the use of alcohol Expectations regarding the positive effects of the drug and /or the alcohol
Psychological factors	Mental health disorders Anxiety Low self esteem Depression Low tolerance for stress Loss of control over situations in life
Genetic factors	Inherited genetic predisposition to alcohol or drug dependence Deficits in neurotransmitters (for example serotonin) an absence of aversive reactions such as palpitations and/ or flushing
Behavioral factors	Impulsive behavior Anti-social personality disorder Avoid responsibilities Poor interpersonal relationships Risk-taking behavior Use of other substances Aggressive behavior in childhood

	Social / cultural norms acceptance of alcohol and the use of drugs Reckless behavior Peers use alcohol Peers use drugs
Demographic factors	Male gender Low socio-economic status Lack / loss of employment
Family factors	Family dysfunction for example inconsistent regarding discipline Use of drugs by parent(s), sibling, spouse Use of alcohol by parent(s), sibling, spouse Lack of positive family routines Family trauma for example divorce or death in the family

Legal and ethical Responsibilities

Each individual has a legal and ethical responsibility to uphold the law and to help protect society from drug abuse.

The health care practitioner has a professional responsibility to prescribe and dispense controlled substances appropriately, and to guard against abuse while ensuring that patients are safe and have medications available when they need it.

The Nurse Practice Act (Florida Statutes 464.018 1K)

DISCIPLINARY ACTIONS

464.018

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(a) Procuring, attempting to procure, or renewing a license to practice nursing by bribery, by knowing misrepresentations, or through an error of the department or the board.

(b) Having a license to practice nursing revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of another state, territory, or country.

(c) Being convicted or found guilty of, or entering a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction which directly relates to the practice of nursing or to the ability to practice nursing.

(h) Unprofessional conduct, as defined by board rule.

(i) Engaging or attempting to engage in the possession, sale, or distribution of controlled substances as set forth in chapter 893, for any other than legitimate purposes authorized by this part.

(j) Being unable to practice nursing with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, or chemicals or any other type of material or as a result of any mental or physical condition. In enforcing this paragraph, the department shall have, upon a finding of the State Surgeon General or the State Surgeon General's designee that probable cause exists to believe that the licensee is unable to practice nursing because of the reasons stated in this paragraph, the authority to issue an order to compel a licensee to submit to a mental or physical examination by physicians designated by the department. If the licensee refuses to comply with such order, the department's order directing such examination may be enforced by filing a petition for enforcement in the circuit court where the licensee resides or does business. The licensee against whom the petition is filed shall not be named or identified by initials in any public court records or documents, and the proceedings shall be closed to the public. The department shall be entitled to the summary procedure provided in s. 51.011. A nurse affected by the provisions of this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate that she or he can resume the competent practice of nursing with reasonable skill and safety to patients.

(k) Failing to report to the department any person who the licensee knows is in violation of this part or of the rules of the department or the board; however, if the licensee verifies that such person is actively participating in a board-approved program for the treatment of a physical or mental condition, the licensee is required to report such person only to an impaired professionals consultant.

(l) Knowingly violating any provision of this part, a rule of the board or the department, or a lawful order of the board or department previously entered in a disciplinary proceeding or failing to comply with a lawfully issued subpoena of the department.

(m) Failing to report to the department any licensee under chapter 458 or under chapter 459 who the nurse knows has violated the grounds for disciplinary action set out in the law under which that person is licensed and who provides health care services in a facility licensed under chapter 395, or a health maintenance organization certificated under part I of chapter 641, in which the nurse also provides services.

(n) Failing to meet minimal standards of acceptable and prevailing nursing practice, including engaging in acts for which the licensee is not qualified by training or experience.

(o) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

(2) The board may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found guilty of violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s. 456.072(1).

(3) The board shall not reinstate the license of a nurse, or cause a license to be issued to a person it has deemed unqualified, until such time as it is satisfied that such person has complied with all the terms and conditions set forth in the final order and that such person is capable of safely engaging in the practice of nursing.

(4) The board shall not reinstate the license of a nurse who has been found guilty by the board on three separate occasions of violations of this part relating to the use of drugs or narcotics, which offenses involved the diversion of drugs or narcotics from patients to personal use or sale.

(5) The board shall by rule establish guidelines for the disposition of disciplinary cases involving specific types of violations. Such guidelines may include minimum and maximum fines, periods of supervision or probation, or conditions of probation or reissuance of a license.

SIGNS OF IMPAIRMENT

Some nurses may misuse substance to cope with problems while going through a stressful period while other nurses have a long history of substance abuse. It may be difficult to detect the impaired nurse because he/ she will be careful to avoid being seen or identified.

Some signs and symptoms that may suggest substance abuse include:

Poor job performance

Excessive sick time/ call-outs

Poor charting

Multiple mistakes

Medication errors

Documentation errors

Difficulty meeting schedules

Leaving work early

Dishonest

Arriving late for work

Orders that are altered

Maximum use of as needed/ PRN pain medicines for the patient

Frequent absences from assigned unit

Obsession with narcotics

Mood changes (after breaks)

Large amount of wasted narcotics

Frequent sign outs of narcotics

Obsession with the Pyxis machine

Discrepancy between patient record and narcotic record

Frequent report of patients not experiencing adequate pain relief

Offer to give medication to other patients; not on assignment

Some physical signs of impairment may include:

Tremors

Fatigue

Sweating

Less alert

Unsteady gait

Sleepiness

Runny nose

Shakiness

Speech is slurred

Changes in appearance

Eyes that are watery

Constricted pupils

Dilated pupils

Weight gain

Weight loss

Some behaviors that may identify the impaired colleague include:

Comes to work on day off

Loiters around the departmental drug supply

Outbursts of anger

Mood changes

Frequent bathroom breaks

Wears long-sleeves; when short sleeves can be worn (to hide needle tract marks)

Increased difficulty with authority

Frequently using mints, gums or mouthwash

Intoxication at social events

Frequent illness or physical complaints

Isolation from peers

Elaborate excuses

Defensiveness

Poor judgment

Frequent complaints of pain

Insomnia

Hypoactivity

Hyperactivity

Poor concentration

Frequent accidents

Steps to Make a Report

Any impaired healthcare practitioner /nurse, colleague should be reported immediately to help that practitioner and the patients by preventing potential harm to them. Reporting the impaired colleague will be helpful because it will help him/her to enter a treatment program and also will help to protect the patients.

The impaired healthcare practitioner /nurse should not be ignored, transferred to another department or be fired and the problem is not addressed, this will result in continued dangerous behaviors, which will continue to put patients at risk and also potential harm to the impaired nurse. It is important for co- workers and supervisors to address and appropriately handle the situation so that the signs of impairment are not ignored and the impaired practitioner /nurse is enabled and continues the abusive behaviors.

The requirements for mandatory reporting of nurses by nurses

FLORIDA REQUIREMENTS

If the nurse observes a co-worker doing something that is suspicious, it is the nurse's role to contact the supervisor and report the observation.

In the state of Florida, any individual who suspects a nurse is impaired must report the nurse to the Intervention Project for Nurses (IPN) and /or the Florida Department of Health. To make a referral to the Intervention Project for Nurses (IPN) and /or confidential consultation;

Contact the Intervention Project for Nurses (IPN) at 1-800-840-2720.

The Intervention Project for Nurses (IPN) also referred to as "an alternate to discipline program for nurses" aka diversion, was established in 1983 through legislative action to ensure public health and safety through a program that provides close monitoring of nurses who are unsafe to practice due to impairment as a result of misuse or abuse of alcohol or drugs, or both, or due to a mental or physical condition which could affect the licensee's ability to practice with skill and safety.

The Intervention Project for Nurses (IPN) often receives reports from:

- Pre-employment drug screen positive for illegal drugs or drugs not prescribed,
- The impaired nurse call and report self, due to behaviors out of their control,
- Diversion cases – Employers report missing drugs
- The nurse is on prescription medications but job performance remains a concern,
- Mental health instability affecting performance
- Physical conditions that may affect one's ability to perform with safety.

The Intervention Project for Nurses (IPN) Program Objectives

To ensure public health and safety through a program that provides close monitoring of nurses who are unsafe to practice, due to the use of drugs including alcohol and/or psychiatric, psychological or a physical condition (chapter 455.261).

To provide a program for the affected nurses, so that they may be rehabilitated in a therapeutic, non-punitive, and confidential process,

To provide an opportunity for retention of nurses within the nursing profession,

To facilitate early intervention, therefore decreasing the time between the nurse's acknowledgment of the problem and his/her entry into a recovery program,

To require the nurse to withdraw from practice immediately, and until such time that the Intervention Project for Nurses (IPN) is assured that he/she is able to safely return to the practice of nursing,

To provide a cost effective alternative to the traditional disciplinary process,

To develop a statewide resource network for referring nurses to appropriate services,

To provide confidential consultations for Nurse Managers.

Criteria used to determine when the nurse can return to practice

The Intervention Project for Nurses (IPN) determines when the nurse can return to practice. Some of the criteria that the Intervention Project for Nurses uses to determine if the nurse can return to practice include:

- That the treatment must be done and the nurse is engaged in the continuing treatment principles such as involvement in a support group.
- A signed advocacy contract must be received.
- The nurse agrees to random urine/ drug screens.

- The nurse agrees to the practice restrictions that have been established.
- Someone to monitor workplace performance will be available to provide feedback.
- The nurse must have a relapse prevention workbook.

Satisfactory progress is determined as the nurses have:

Negative drug screens,

Compliance with the individualized contract

Monitoring reports that are good,

Attends monitoring and support groups

Monitoring reports are supplied by the employers, nurse in recovery, support group facilitators and the treatment providers.

Successful completion

Successful completion of the program includes validation of progress and stability of the nurse. Also readiness to practice is established. After completing the program successfully, the record is then sealed.

However if the nurses do not exhibit appropriate progress, stop treatment or does not comply with the program stipulations the Intervention Project for Nursing (IPN) will report the nurse to the Department of Health.

Health-related programs for alcohol and substance misuse.

Employee programs refer to activities that include active employee involvement, such as classes, seminars or competitions.

Employee programs are frequently provided on-site at the workplace.

Employee Assistance Programs (EAPs)

Employee Assistance Programs (EAPs) can offer information and referral services for employees with alcohol or drug use problems. Encouraging healthy behaviors is an appropriate adjunct to standard therapies for substance misuse.

As mentioned earlier, several behaviors regarding job performance indicate a high likelihood that an employee has problematic alcohol or drug use:

A pattern of poor quality of work

A pattern of poor quantity of work

Attendance problems,

Problems related to interaction with patients, colleague or the families,

Some employees may self-identify that their misuse behaviors are causing problems,

When these problems are identified the employee can be referred to the Employee Assistance Programs (EAPs) for additional assessment,

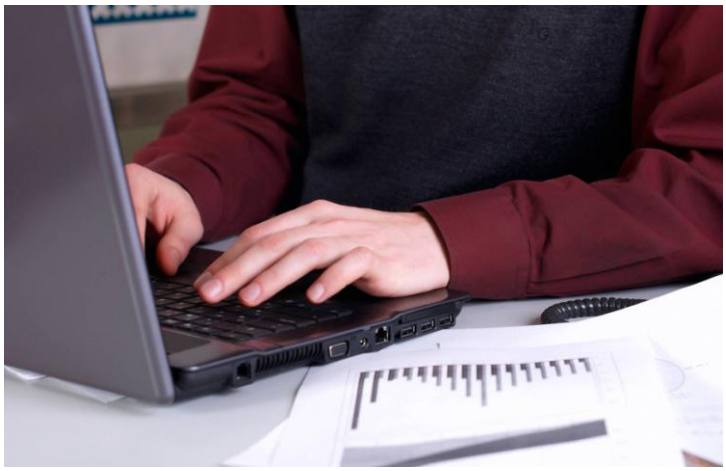
Support education programs through an Employee Assistance Programs (EAPs) or health promotion program,

Employees need education on recognizing signs and symptoms of misuse in themselves and others,

Worksite health fairs, education campaigns and Employee Assistance Programs (EAPs) brochures should include information on alcohol and substance misuse and specific information on obtaining confidential counseling and referral through Employee Assistance Programs (EAPs) programs.

Additionally, support can be provided through programs such as:

- Alcoholics Anonymous or Al-Anon and the availability of counseling, diagnosis and treatment services,
- Worksite health promotion such as nutrition programs and /or physical activity can reduce alcohol and drug misuse.



DOCUMENTATION IN PATIENT RECORDS

Documentation is a set of documents that is used as a form of communication. Documentation can be provided on paper, online or on digital or analog media such as audio tape or CDs. It is becoming less common to see paper (hard-copy) documentation. Documentation can be distributed via the website, software products, and other on-line applications. Within the health care setting, documentation is a form of communication that provides information about the healthcare that the patient receives. Accurate and complete documentation of patient care is required by the facilities/institutions providing services to patients/residents, accreditation agencies, reimbursement agencies, federal and state governments; Medicare and Medicaid.

Some of the purposes of documentation include:

- Fulfilling professional responsibility and establishing accountability
- Legal standards
- Compliance with standard of practice
- Communication among the health care team and providing education to staff
- To provide continuity of care

- Providing information for research
- For reimbursement.

A COMPLETE MEDICAL RECORD

A complete medical record must have an accurate and complete representation of the actual care/experience of the resident/patient in the facility. It needs to have enough information to demonstrate that the institution knows the status of the resident/patient, has care plans identified to meet the resident's/patient's conditions, and provides enough documentation of the effects of the care provided. Documentation should provide a picture of the resident /patient and the results of treatment and the resident's/ patient's response to the treatment. Documentation should also show the changes in status or condition of the resident/patient and any changes in orders or treatments.

THE CERTIFIED NURSING ASSISTANT (CNA)

THE SCOPE OF PRACTICE FOR THE CERTIFIED NURSING ASSISTANT (CNA)

The role as a CNA/HHA; the Florida Statutes describe below, provides specific guidelines regarding the role of the nursing assistant within the long term and home health care settings.

The Florida Statutes 400.211 Persons employed as nursing assistants; certification requirement:
(1)To serve as a nursing assistant in any nursing home, a person must be certified as a nursing assistant under part II of chapter 464, unless the person is a registered nurse or practical nurse licensed in accordance with part I of chapter 464 or an applicant for such licensure who is permitted to practice nursing in accordance with rules adopted by the Board of Nursing pursuant to part I of chapter 464.

Chapter 464 of the Florida Statues

(5) "Practice of a certified nursing assistant" means providing care and assisting persons with tasks relating to the activities of daily living. Such tasks are those associated with:

- personal care,
- maintaining mobility,
- nutrition and hydration,
- toileting and elimination,
- assistive devices,
- safety and cleanliness,
- data gathering,
- reporting abnormal signs and symptoms,
- postmortem care,
- patient socialization and reality orientation,
- end-of-life care,
- cardiopulmonary resuscitation and emergency care,
- residents' or patients' rights,
- documentation of nursing-assistant services, and other tasks that a certified nurse assistant may perform after training beyond that required for initial certification and upon validation of competence in that skill by a registered nurse.

Florida Statues 464

(7) A certified nursing assistant shall complete 12 hours of in service training during each calendar year. The certified nursing assistant shall be responsible for maintaining documentation demonstrating compliance with these provisions. The Council on Certified Nursing Assistants, in accordance with s. 464.2085(2)(b), shall propose rules to implement this subsection.

CONFIDENTIALITY

Confidentiality is defined as a set of rules or a promise that limits access or place restrictions on certain types of information. Within the health care setting, confidentiality is a major issue in patient/resident care. Certified nursing assistants as well as everyone who works with the patient has to maintain confidentiality of patient information. For example: you cannot talk about the patient with others who are not working with the patient and you cannot leave patient's chart at the bedside for unauthorized personnel

to view. Legally, you can be fined or imprisoned; if you talk about the patient or share patient information. HIPAA laws must be followed and maintained.

Health Insurance Portability and Accountability Act (HIPAA)

Confidentiality of patients' information
HIPAA violations involves both civil and criminal penalties which include fines and imprisonment. The fines can range from $100 for each violation of the law to a limit of $25,000 per year for multiple violations. For misusing or disclosing any of the patient's information, criminal sanctions carry fines of 50,000 to 250,000 and one to ten years imprisonment.

Always maintain confidentiality of patients' information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security and Breach Notification Rules:

The Office for Civil Rights enforces the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which protects the privacy of individually identifiable health information; the HIPAA Security Rule, which sets national standards for the security of electronic protected health information; the HIPAA Breach Notification Rule, which requires covered entities and business associates to provide notification following a breach of unsecured protected health information; and the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety.

The HIPAA Privacy Rule provides Federal protections for individually identifiable health information held by covered entities and their business associates and give the patient an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it allows the disclosure of health information needed for patient care and other important purposes.

Protected Health Information (PHI)

The HIPAA Privacy Rule protects most "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form; electronic, on paper, or oral. The Privacy Rule calls this information protected health information (PHI). Protected health information is information, including demographic information, which relates to:

- the person's present, past, or future physical, mental health or condition,
- the provision of health care to the individual, or
- the present, past, or future payment for the provision of health care to the individual, and that identifies the person or for which can be used to identify the individual.

Protected health information includes many common identifiers such as name, address, Social Security Number, date of birth when they can be associated with the health information.

A medical record, hospital bill or laboratory report, would be Protected health information because each document would contain a patient's name and the other identifying information associated with the health data content.

LEGAL DOCUMENTATION

Certified Nursing Assistant (CNA)

Legal documentation involves:

- Careful and accurate charting, never document a task if it was not done, this too is illegal (always notify the nurse for assistance as needed),
- Never document for another CNA, this is illegal,
- Always document the facts,
- Do not place personal feelings in the chart
- If you observe something abnormal with the patient, do not just write it down; make sure the charge nurse is notified so that the patient can be assessed,
- only document care when it is given,
- Avoid using abbreviations, Potential for errors (refer to the Do not use list)

- Make sure hand writing is clear and can be read by others of the health care team, everything that you document or chart can be used in court and the lawyers and everyone involved in the legal team must be able to read it.

NURSE

Nurses need to know the state law, the policies and the professional standards that relates to the specialty in which they are practicing. If there is any doubt or lack of knowledge consult with a supervisor or an expert to assist.

THE NURSE PRACTICE ACT

Florida Statues 464 states:

464.002 Purpose: The sole legislative purpose in enacting this part is to ensure that every nurse practicing in this state meets minimum requirements for safe practice. It is the legislative intent that nurses who fall below minimum competency or who otherwise present a danger to the public shall be prohibited from practicing in this state.

Members of the Health care Team

As previously mentioned, it is very important to complete appropriate documentation within the patient's medical record because other members of the healthcare team will also be reviewing and reading the document. Therefore always provide information about the patient that is current, accurate, factual, complete, and it reflects a picture of the resident/patient while under the care of each health care worker (nurse, CNA, physician etc.)

Goal of Documentation

The overall goal of the nursing documentation is to:

- Ensure that there is documented timeline for the care that the patient receives. Every entry that is completed by each nursing staff or members of the healthcare team has to be coordinated. This coordinated documentation will allow members of the health care team and other who need to review the chart, to see the

patient's status at specific times and assist the health care team in determining if changes have occurred within the patient and at what time the changes were observed, reported and documented.

- Always remember that documentation is considered a legal document which reflects the care the patient received and should reflect that patient care was given in accordance with appropriate standards of care.

Personnel completing the documentation

As a health care worker, you are also documenting for your own purpose. When you have appropriately documented, this documentation will be available for you to access as needed, if you need to recall complete details of what did for the patients.

If there is a lawsuit or claim filed within a year or more, you might not remember all the details of care given to that patient or even the time that care or medications were administered therefore your complete and accurate documentation will be useful at that time. See your state for the statute of limitation (time frame); within some states, the statute of limitations allows lawsuits within 2 years or more of the date of the event resulting in a claim. The timeframe may be extended as much as 20 years if the patient involved is a minor.

Everyone within the health care team must document and the documentation should be at the time of patient care so that the information is accurate and complete. Never leave your shift without documenting; never say "I will come back in the morning and document."

Lawyers, consultants, Judge and Jury

When there is a lawsuit, all of the documentation of the patient's medical record will be reviewed by the lawyers, consultants, nurses and other experts involved. The team will look for what was not done per standard of care, what could have been done better, what was not accurately done, what was not done that should have been completed etc. The documentation will be read by the jurors involved in the case.

Follow the nursing process

The nursing process should always be followed. The nursing process requires :

- Assessment,
- Nursing diagnosis,
- Planning,
- Implementation, and
- Evaluation.

Assessment

Assessment is the first step in delivering nursing care.
Nursing assessment is defined as the gathering and analyzing of information about a patient's physiological, economic, psychological, sociological, cultural and spiritual status.

Diagnosis

The nursing diagnosis is the nurse's clinical judgment about the patient's response to actual or potential health status/conditions.

Planning

Based on the assessment and diagnosis, the nurse establishes measurable and achievable short- and long-term goals and expected outcomes for the patient. The information is placed in the plan of care.

Implementation

Implementation involves carrying out the nursing care according to the plan of care.

Evaluation

Ongoing evaluation is completed to check the patient's status and the effectiveness of the nursing care. The care plan is then modified as needed.

State nurse practice acts may vary from state to state so follow the established guidelines for documentation. Some tips for accurate and complete documentation are listed below:

- Always write clearly (legibly), everyone within the health care team needs to be able to read what you have documented. This is vital to accurate and continuity of care for the patient. It is good to use block printing if your handwriting is illegible.

- Avoid charting in advance, this too is illegal and can lead to devastating errors.

- Always complete your documented entry using a chronological documentation format. This will provide separate entries for each narrated item because you want to provide a clear picture of the events and times surrounding the care that was provided for that patient.

- Document timely; charting should be done every 1-2 hours for routine care. Medication administration and other interventions or changes in condition should be documented immediately. If medications are not recorded in a timely manner, there is a possibility that the patient may receive that medication again.
- When standard time is used, always include AM or PM with notations. Some healthcare facilities use military time to reduce errors.
- Your Signature is very important. The healthcare worker must always sign for every notation in the patient's medical record.
- If you are to assess the patient's baseline mental status, document it because if there is a change or deviation noted from baseline this could indicate an injury or an acute illness.
- If you completed a task or an intervention, always document the intervention followed by an evaluation; did the intervention help the patient, was it effective? If intervention was not effective, what was done? Was the physician updated, all basis covered? Patient's needs met?

- Also document any complaints of the patient and/ or family and ensure follow up is done with the supervisor, with timely resolution and documentation.

- If you document a body system abnormality, always note the details because over a period of time the abnormality may become worse.

- Always accurately document how your assessment was done. For example, if you watch the chest of the patient rise and fall, you cannot document that the patient has normal breath sounds unless you have used the stethoscope to listen to the lungs.
- Do not use abbreviations unless they are approved, acceptable and included in your facility's policy and procedure. Therefore if you are unable to complete an entry on that page, do not shorten the word (do not make up your own word) move to the next page; follow your facility's policy and procedure for continuing an entry on the next page.
- Do not use slangs within the patient's medical record. As mentioned before the patient's medical record is a legal document. All documentation should be in Standard English with accurate grammar. Accurate spelling is also required because misspelled words may lead to different interpretations.

- Writing must be done using permanent ink pen (dark ink, blue or black) and writing needs to be neat and legible. Do not use pencil or pen that can be erased. Check your facility policy, some only allow black ink.
- Always assess the patient at the time of admission, transfer and discharge. You need to know the status of a patient when he/she enters your care and before he/she leaves.

- Avoid leaving spaces in charting. If blank spaces are left, this will allow others to make additions to the patient's medical record, to your notation. Make a straight line through any empty space.

- Make sure if you have to complete a late entry, always follow your facility's policy. Late entries must indicate the date and time they were actually entered into the patient's medical record, and you have to include the notation -*Late entry*; followed by the date and time of the event.

- When medications or treatments are delayed, the healthcare worker must document in the patient's medical records, noting the reason for the delay. For example, the patient may be completing a diagnostic examination and has not

yet returned to the unit. If aware that the patient is scheduled for the examination, prioritize and make plans to complete the treatment before the patient leaves for the examination; if possible.

- When you have to continue notes from one page to another, make a notation that the entry is continued on the next page, this is to indicate that the note is not complete. Then document also on the next page to indicate that it is a continuation. Both of the pages have to contain your signature.(Follow your facility's Policy).
- When making corrections in the medical record, the error cannot be white-out, erased, scratched out to make illegible. The error can be corrected by drawing a line through the text and writing the word "error." sign your name and date the cross off. Follow your facility policy.

Always remember !!

• Writing has to be legible –clear for others to read and understand
• Use dark ink pen on the patient's medical records
• Whenever you make an error, use your pen and cross it off with **one thin line**. Write error, sign your name and date the cross off. Do not try to cover up the mistake with marker or scribble. Do not rewrite over the error; just one straight line through the error. White out cannot be used when you make a mistake.

Documentation Variations among health care institutions

Healthcare workers often work in various settings. Physicians, nurses, CNAs and other healthcare personnel often work in more than one facility at the same time. Therefore it is very important to understand the basic formats for effective documentation. Appropriate and accurate documentation requires the nurse to have an understanding of the nursing process and nursing diagnosis.

NANDA International (formerly the North American Nursing Diagnosis Association) is a professional organization of nurses standardized nursing terminology that develops,

researches, disseminates, refines the nomenclature, criteria, and taxonomy of nursing diagnoses.

NANDA International sets the standards for nursing diagnoses with a taxonomy that includes domains, classes, diagnoses, based on health patterns; domains such as:

Activity/Rest
Comfort
Coping/Stress Tolerance
Elimination
Growth/Development
Health Promotion
Life Principles
Nutrition
Perception/Cognition
Role Relationships
Safety/Protection
Self-perception
Sexuality

Nursing Interventions Classification (NIC) and Nursing Outcomes Classification (NOC)

Nursing Interventions Classification; a standardized list of several of different interventions and activities needed to implement the interventions. The patient outcomes related to the nursing interventions classification are detailed in the Nursing Outcomes Classification (NOC), which contains several outcomes, each with measures to determine if outcomes are met.

NANDA International Nursing Diagnoses: Definitions and Classification 2015-2017 is available and approved by NANDA-I. The new 2015-2017 edition has been updated and revised throughout. There are 235 diagnoses presented and are supported by definition, defining characteristics, related factors, or risk factors. The new / revised diagnosis is based on latest global evidence, and approved by expert nurse

diagnosticians, educators and researchers. (See the new 2015-2017 edition for updates).

Computerized documentation systems

Computerized documentation systems often incorporate nursing diagnoses into the system, which produces lists of interventions and expected outcomes. More institutions are utilizing computerized systems for documentation. These computerized systems however vary from one facility to another; however security is a common factor for all systems. Training has to be provided for the staff, which usually include securing patient information from unauthorized persons whether the computer is at the nurses' station or at the bedside, security of password information; no one is allowed to share their password with their co-worker etc. Computer systems usually track the use of the system, therefore it is documented who is logged on and time and date. There has to be training regarding how to correct errors when an entry error is made. Computerized documentation systems have many advantages, including but not limited to:

- Eliminates handwritten orders,
- The records are legible; no need to worry about unclear handwriting,
- Enters signatures automatically,
- Security of patient information; need password to log in to access patient information,
- Orders can be automatically transmitted to pharmacy and medication is ordered quickly,
- Reduction in errors,
- Prevents tampering of the medical record,
- Difficult to delete information from the record.

Computerized documentation systems may include:

Electronic medical record (EMR)

Electronic medical record is the computerized patient medical record. With the use of the computerized documentation system, computer terminals may be located in the patient's room, therefore healthcare providers / workers, professionals have to be educated/ trained regarding the importance of logging off the computer system so that persons who are not authorized will not be able to access and view the patient's information. The computerized documentation system usually has computerized physician order entry, clinical decision support system; therefore the notes can be entered electronically.

Clinical decision support system (CDSS)

Clinical decision support system refers to the interactive software systems which has evidence based medical information. Clinical decision support system can be used for different purposes such as providing diagnosis and treatment options when the symptoms are imputed into the computer system. Clinical decision support system may also monitor the orders and the treatments to prevent repetitions or duplications.

Computerized physician or provider order entry (CPOE)

Computerized physician or provider order entry (CPOE) refers to the interactive software application that automates ordering for medications or treatments. Orders must be entered in a prompted format that eliminates many errors. These systems usually include Clinical decision support system to provide alerts if there is an inaccurate dose or duplication order. Computerized physician or provider order entry eliminates handwritten orders and the information is automatically transmitted to the pharmacy, reducing errors and medication is ordered quickly.

Documentation Formats

Many institutions utilize the narrative format when documenting in the clinical record. Healthcare workers must utilize the system that is in place / follow the policy and procedures of the facility that they work in.

Some of the formats that are available include:

- Narrative format
- Focus
- Charting by exception (CBE)
- Problem Oriented medical record (POMR)
- Flow Sheet, Assessment, Concise, Timely (FACT)
- Problem/ intervention/ Evaluation (PIE)
- Core

Narrative format

Narrative format is used in the most of the institutions. Narrative charting involves recording data using progress notes, with the flow sheets supplementing the notes. Narrative charting does not follow a specific outline and follows the thought process of the healthcare worker who is documenting.

Focus

Organized into patient centered topics, the Focus system encourages integrating assessment data to evaluate the patient's condition on an ongoing basis. The Focus system is best used where the procedures are repetitive and is utilized primarily in acute care settings. Progress notes are written utilizing the DAR (Data, Action, and Response) format.

Charting by exception (CBE)

Charting by exception requires the development and use of practice standards or protocols for each body system. The forms utilized in the documentation are developed following specific guidelines. Developing the standards and forms eliminates the need to document in narrative format standard nursing care. The healthcare worker check off the areas on the flow sheet through which the patient has met the established standard, then writes a narrative note when the patient's condition deviates from the established standard.

Problem Oriented medical record (POMR)

Problem oriented medical record (POMR) is utilized in many health care institutions. The POMR system follows a problem list format, identifying all areas (both positive and negative) that are impacting the patient. The notes and all the documentation refer back to the problem list, using the Subjective, Objective, Assessment, Plan (SOAP), the Intervention, Evaluation (SOAPIE) and/or SOAPIER (Revision) format.

Flow Sheet, Assessment, Concise, Timely (FACT)

Flow Sheet, Assessment, Concise, Timely (FACT) developed to help eliminate repetitive notes, irrelevant data, inconsistency and to reduce amount of time required to complete documentation. Flow sheets are designed to address the redundant activities in caring for a resident. The narrative documentation utilizes the Data, Action, Response (DAR) format of the Focus charting system.

Problem/ intervention/ Evaluation (PIE)

Problem/ intervention/ Evaluation (PIE) organize information according to the patient's problems to simplify the documentation system. Problem/ intervention/ Evaluation (PIE) utilize flow sheets which have been developed for daily documentation supplemented with structured narrative documentation. This system also integrates the care plan into the daily documentation.

Core

Core focuses on the nursing process. The Core framework utilizes the data base, flow sheets, care plan, progress notes, discharge summary to chart the patient's needs and progress. Progress notes follow the data, action, evaluation/response (DAE) for each of the problems.

Use of abbreviations

Abbreviation is a shortened form of a word or phrase. Abbreviations can lead to some serious or life threatening errors, therefore there are guidelines in place. The Joint Commission has set guidelines and rules; all healthcare settings has to standardize abbreviations, acronyms and symbols that they are using. They are also required to adhere to a Do Not Use list.

The Do Not Use List includes some of the following:

Do Not Use u, or for unit. Mistaken some times for zero. You must write “unit”
Do Not use iu for international unit. Mistaken for IV. Write “international unit”
Do Not Use Q.D., QD, q.d., qd (Daily). Mistaken for each other. Write “Daily”.
Do Not Use Q.O.D. QOD, q.o.d., qod (every other day). Write “every other day”
See the complete Do Not Use List (The Joint Commission http://www.jointcommission.org/assets/1/18/Do_Not_Use_List.pdf**)**

Timely Documentation

Time is a very crucial factor within the nursing process. Healthcare workers; Physicians, Nurses, CNA have to document the time of all interventions and notations. For example, the patient complains of severe pain to the fractured extremity, the nurse administered the pain medication prior to leaving the shift; no notation was completed. The patient reports pain to the oncoming nurse, who is aware that patient has a fracture and will experience pain, therefore administers the pain medication; within the hour the patient has received pain medication twice. Another scenario; the CNA obtained vital signs at 7am at 2:30pm the patient reports feeling ill, flushed and experiencing severe headache; the CNA gives the nurse the results of the vital signs assessment which was documented as completed 2:30pm this may lead to inappropriate interventions and inaccurate reporting to physician regarding patient’s status.

Documentation /Physician orders

Telephone order and Verbal order

Always follow the institution’s Policy when noting orders on the physician order sheet. When the nurse receives a telephone order (the physician telephones and gives an order)then it has to be documented as a Telephone Order (T.O.) The telephone order should indicate a telephone order with the time, date, physician’s name and that the

order has been repeated to the physician, also Verbal orders, must be documented as V.O. and must be written exactly as dictated and then verified.

Vital Information

Some information such as allergies/ sensitivities, Patient's identification; name and other identifying information should be on every page of every document in the patient's medical record.

Notation of Medications and treatments

When medications and treatments are administered, the healthcare worker has to document in the patient's medical record. Also If the wrong medication or treatment is administered, this also has to be documented. The nursing note has to indicate all treatments and medications given to the patient, even if it was the wrong medication or treatment. The individual who administers the wrong medication or treatment has to document the:

- Name of the medication
- the dose of medication,
- Name of physician notified
- time the physician was notified,
- Nursing interventions or physician orders to prevent or treat adverse effects,
- Patient's response to treatment.

Follow the facility policy and procedure regarding with medication and treatment errors. An incident report will also be completed.

LONG TERM CARE DOCUMENTATION

Within the long term care setting the individuals who residents and receives care are often referred to as residents, clients, patients and some facility "customers". Follow the institution policy and ensure that your documentation includes the appropriate name.

Complete and accurate documentation within the long term care setting is also very vital due to several factors such as:

- Regulations
- Surveys conducted by The Agency For Health Care Administration (AHCA)
- Litigations (laws suits)
- Documentation based on reimbursement/ payment systems
- Increased legal challenges
- Complex clinical needs
- Complex patient decision making

Federal Regulations and Clinical Record guidelines

Long-term care facilities such as Skilled Nursing Facilities (SNF), rehab. centers often review their documentation policies and procedures/ guidelines. They frequently have to incorporate accreditation requirements, payer requirements (for reimbursement purposes) and state regulations into the documentation systems.

Federal regulation requires that the facility has to maintain clinical records on each resident/patient in accordance with accepted professional standards and practices that are:

- Accurately documented,
- Complete,
- Readily accessible and
- Systematically organized.

LONG TERM CARE RECORD

Certified Nurse Assistant (CNA)

Once again, the certified nurse assistant may perform tasks associated with:

- personal care,
- maintaining mobility,
- nutrition and hydration,
- toileting and elimination,
- assistive devices,
- safety and cleanliness,
- data gathering,
- reporting abnormal signs and symptoms,
- postmortem care,
- patient socialization and reality orientation,
- end-of-life care,
- cardiopulmonary resuscitation and emergency care,
- residents' or patients' rights,
- documentation of nursing-assistant services, and other tasks.

The certified nursing assistant is also required to perform accurate and complete documentation within this setting.

NURSING DOCUMENTATION IN THE LONG TERM CARE SETTING

Admission Record

Every clinical record needs to have an admission record or face sheet or that provides the demographic information, diagnosis, financial, insurance information, patient's/ resident's responsible party and contact(s) and other contact information for other professionals involved in the patient's/ resident's care outside of the facility for example, attending physician etc. The face sheet has to be revised and updated with

changes as they occur. Long Term care and other facilities have designated individuals who are responsible for this task. Sometimes a nurse or nursing supervisor may be responsible for adding new information when changes occur after regular business hours; then the designated medical records personnel is updated and log the changes. The old face sheet is kept in another designated section of the chart. Nothing is thrown out from the medical record even after several changes or updates are made.

Admission Assessment:

An admission or readmission assessment usually incorporates data that would be considered a nursing assessment and the physical examination. Although there is no Federal regulation to perform the admission assessment, professional practice standards for the healthcare industry indicates that an admission assessment should be completed so that there will be baseline information and better awareness of the client/ resident needs so that appropriate and accurate care plan can be initiated. State regulations may provide specific details on information to collect such as vital signs, pain assessment, a review of systems, skin integrity etc.

Assessments within Long Term Care

There are several assessments that are used within the long term care environment. Some include:

- Resident Assessment Instrument (RAI)
- Nursing Assessment,
- Pain Assessment,
- Fall Risk Assessment,
- Pressure ulcer risk assessment
- Dietary assessments
- Elopement Assessment,
- Bowel and Bladder assessment
- Social Service Assessment,
- Smoking assessment etc.

Assessments can be documented in various ways. Documentation of an assessment may be simple as completing an assessment form or writing a narrative assessment.

The Resident Assessment Instrument (RAI)

The Resident Assessment Instrument (RAI) is the mandated assessment tool under the Federal Omnibus Budget Reconciliation Act of 1987 (OBRA) that is required in Long term care settings. Then RAI assessment also includes assessments required by the Prospective Payment System (PPS).
Some of the Omnibus Budget Reconciliation Act (OBRA) requirement includes:
Comprehensive Admission assessment
Quarterly Assessment
Significant Change
Annual assessment
Significant Correction to Prior Quarterly Assessment
Significant Correction to Prior Comprehensive Assessment

Prospective Payment Required
5 day Assessment
14 day Assessment
30 day Assessment
60 day Assessment
90 day Assessment
Other Medicare Required Assessment (OMRA)
Readmission/Return
Start of Therapy (SOT)
End of Therapy (EOT)
End of Therapy revised (EOT-r)
Start and End of Therapy
Change of Therapy (COT)
Other required records/assessments
Entry record
Discharge Assessment return anticipated
Discharge Assessment return not anticipated

Death in Facility

Types of Assessments and Requirements:

Some of the following assessments are required by Federal regulation and others are standard practice within the healthcare industry. The assessments may be completed on separate forms; the format may be manual or electronic or may be documented in narrative notes.

Preadmission Assessment and Admission Assessment:

Completion of a preadmission assessment is not required by Federal regulation, but is commonly completed to obtain information and determine the needs of the resident/ client and ensure that the institution /facility has adequate resources to provide care for that resident.

Admission Assessment – mentioned above.

Fall Assessment Documentation

The facility/ institution has to identify each client/ resident who is at risk for accidents/incidents and/or falls and appropriately document, care plan and implement measures/ procedures to prevent accidents. Due to the time allowed to complete the Resident Assessment Instrument (RAI), it is recommended that the risk for falls assessment be completed on admission and readmission. Some of the risk factors may include:

- AGE,
- Medications that the resident is taking may have side effects such as dizziness, hypotension etc.
- sedation,
- Patient has a history of falls,

- Diagnosis that increase risk for falls,
- Infection,
- sensory impairments,
- sleep disorders,
- confusion,
- Patient has unsteady gait,
- Poor balance,
- Patient requires assistance with walking,
- Patient may require assistance for transfer,
- History of wandering,
- orthostatic hypotension,
- poor judgment,
- Pain,
- urinary frequency,
- urinary incontinence
- weakness

The healthcare worker / nurse has to document /include the risk factors in the care plan should include the risk factors and the interventions to be implemented to try to prevent falls or other accidents. Based on the Fall risk assessment findings interventions may include:

- Monitoring for side effects of medications,
- Ensure patient has assistive devices; such as cane, walker or wheelchair to assist with mobility,
- Assistance with ambulation,
- Ensure non-skid footwear,
- Referral to Physical Therapy for Eval /strength building exercises,
- Provide a clutter free environment,
- Ensure patient has eyeglasses in place prior to ambulation,
- Pain management,
- Adequate nutrition and fluids,
- Toileting schedule,

- Remove objects in walkway,
- Ensuring adequate lighting etc.

Within the long term care setting the fall risk should be reassessed with each Resident Assessment Instrument (the MDS), with change in the resident condition, and after every fall. The plan of care should also be reviewed after each fall and revised to include a different intervention to try to prevent another fall from occurring.

The Minimum Data Set (MDS) is part of the U.S. Federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. The MDS provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staffs identify and treat health problems.

The Minimum Data Set is a powerful tool for implementing standardized assessment and for facilitating care management in nursing homes. MDS 3.0 has been designed to improve the reliability, accuracy, and usefulness of the MDS, to include the resident in the assessment process, and to use standard protocols used in other settings.

Skin Assessment documentation

Documentation regarding the resident's skin integrity is very important. Based on the comprehensive assessment the facility must make sure that a resident who is admitted to the facility without a pressure ulcer or skin impairment, does not develop pressure ulcers or skin breakdown unless the resident's clinical condition indicates that they are unavoidable. If the residents develop pressure ulcer or skin impairment, they must receive the necessary treatment and services that will promote healing, prevent infection, prevent new ulcers and prevent increasing size/ stage of pressure ulcers from developing.

The nurse has to document progress with each treatment, whether there are signs or symptoms (s/s) of infections noted and follow up with the physician for change in treatment as needed. The resident's skin condition must be reviewed for each MDS including the discharge assessment. Although it is not a requirement, it is advisable that documentation regarding the resident's skin condition be provided when the resident departs and returns from a leave of absence, for example out with the family, or other events away from the facility. This will provide information regarding the presence

or absence of bruises that may be determined to be facility acquired if it is not documented that the injury was sustained while the resident was out of the facility.

The documentation has to support:

- The promotion of the prevention of pressure ulcer development,
- The promotion of the healing of pressure ulcers and infections, and
- The prevention of the development of additional pressure ulcers.

Documents for the identification and documentation of resident's at risk or with existing pressure ulcers include:

- Skin Assessment; the nurse has completed a visual examination of the skin on admission,
- History & Physical (H&P) and Discharge Summary medical findings,
- Dietician Evaluation,
- Laboratory Work/ blood work,
- the use of a standardized skin at risk assessment for example the Braden scale,
- Intake and Output Totals (I &O),
- Resident Assessment Instrument

Skin at Risk Assessment

When there is early identification of the risk areas, this helps to facilitate prompt implementation of the plan of care; which documents the interventions needed to stabilize, decrease, or remove the risk factors.

Some of the Risk Factors include:

- Impaired mobility /decreased mobility,
- weight loss, medical diagnoses,
- decreased functional ability,

- co-morbid conditions, for example, diabetes mellitus, end stage renal disease or thyroid disease,
- medications such as steroids that may affect wound healing,
- history of healed ulcers,
- decline in appetite,
- impaired blood flow, such as arterial insufficiency,
- resident refusal of care and / or treatment,
- skin exposed to urinary and fecal incontinence,
- cognitive impairment,
- malnutrition, and hydration deficit,
- devices that may cause pressure

The care plan documentation should include the risk factors and the interventions to be implemented to try to reduce or eliminate risk factors related to skin at risk and/or pressure ulcers. Based on the assessment findings the interventions may include:

- Preventative Skin Care,
- Turning and repositioning,
- Pressure relieving devices on beds and chairs,
- Management of pain,
- Encouraging ambulation,
- Encouraging movement,
- Encouraging time out of bed,
- Placement of supportive surfaces to reduce pressure in bed and chair,
- Nutritional approaches that have been designed for adequate nutritional support,
- Adequate fluid intake etc.

Actual Skin Problems

Accurate and complete documentation must be completed on admission and should include the skin assessment. A complete review of the resident's skin, from head to toe must be completed to establish a baseline. There should also be ongoing documentation of the skin integrity so that change in skin integrity can be addressed and treated promptly. Long term care facility usually has an on-going system in place to assess the condition of the skin such as routine monitoring for skin conditions which

could occur at the time of the resident's bath or shower. The Certified Nursing Assistants documents and if abnormal findings are observed the CNA reports the findings/ observations to the nurse, the charge nurse or nursing supervisor who would then check the resident's and follow up with physician and others of the health care team as needed.

The documentation of Assessment and Treatment of Pressure Ulcers include:

Identification of the skin's condition upon admission,
Measurements,
monitor on an on-going basis throughout the resident's stay,
potential for development of additional pressure ulcers,
Characteristics of ulcer,
Factors that influence the development of the pressure ulcer,
Potential for deterioration of existing pressure ulcers,
Stage of ulcer including if ulcer is not stageable,
Description of ulcer,
Color of skin surrounding ulcer
Signs /symptoms of infection,
Potential complications,
Presence of pain,
Change in the level of pain,
Progress toward healing,
Dressings and treatments,
Description of the skin surrounding dressing, when dressing is not due to be changed,
Monitor for the presence of complications.

Documentation must be completed according to the policy and procedures of the facility. Documentation is usually done with each dressing change and can be noted :

- In a narrative format in the progress notes,
- On a specific flow sheet or,
- On the reverse side of the Treatment Record.

Charting should include:

- Date and time of documentation,
- Stage of the pressure (document if it is unstageable)
- Document the location,
- Dimensions and presence of undermining / tunneling
- Drainage/ exudates,
- If drainage is present is it (serous, what color is it, presence of odor, purulent, and approximate amount of drainage)
- Document if resident reports pain,
- if pain is present ; document the nature of the pain, frequency, continuous or intermittent,
- Does resident report relief after treatment or increase pain,
- Document the wound bed; color, characteristic of tissues; necrosis or granulation,
- Describe the wound edges and the surrounding tissues; any redness, rolled edges, hardness or maceration,
- Document whether there are signs / symptoms of infection,
- Document response to treatment also is the resident compliant with treatment plan or non-compliant,
- Update physician if there is lack of healing, or increase deterioration and all abnormalities including resident non-compliance if applicable and document.

Whenever the documentation reflects that an intervention was either not applicable or not feasible, there has to be adequate documentation from the healthcare worker and the practitioner of clinically valid reasons why the interventions were not implemented.

Re-Evaluation and Documentation

If the pressure ulcer does not show some evidence of healing within two to four weeks, the pressure ulcer and the resident's overall clinical status needs to be reassessed.

The healthcare team needs to re-evaluate the treatment plan and determine whether to continue the treatment or change the current interventions. If the healthcare team decides to keep the current treatment regimen, there has to be documentation regarding the reasons for continuing the present treatment when there has been no progress towards healing.

Skin ulcers or abnormalities are documented in the resident's Care Plan. The interventions and the implementation of these interventions are critical and should include preventative measures.

Interventions to treat pressure ulcers may include, but not limited to:

- Turning and repositioning
- Protective skin care
- Using pressure relieving devices on beds and chairs
- Effective pain management
- Ensuring nutritional supplements
- Adequate fluids
- Treatments as ordered by physician

Documentation regarding Bowel and Bladder

On admission to the facility, the Admission Nursing Assessment identifies the status of the resident such as:

- Continence status as described by resident,
- Continence status by observation,
- Risks or conditions that may affect continence,
- Environmental factors that may affect the ability to access the toilet, ambulatory devices or status,
- If catheter is present; documentation of medical justification for the catheter, type and size of catheter, color of urine, flow of urine, potential for removal of catheter,

- The use of medications that may affect continence, etc

Documentation /progress notes for bladder and bowel retraining programs are usually recorded weekly until the resident has reached the goal or the program is discontinued.

Documentation regarding Self-Administration of Medication

If the resident requests to self-administer medications, the interdisciplinary team needs to determine that it is safe for the resident to self-administer drugs before the resident is allowed to do so. The assessment may include cognitive status, vision and manual dexterity. If it is determined that the resident is capable and is a suitable candidate for a self-medication program, the physician is notified and an order is obtained. Documentation within the plan of care needs to reflect the self-medication program and goals. Narrative notes or flow sheets will reflect the resident's progress in the program.

Documentation regarding Nutrition

The institution needs to make sure that the residents maintain acceptable nutritional status, for example ideal body weight and albumin/protein levels; unless the resident's clinical condition demonstrates that it is not possible. When a nutritional problem is identified the institution needs to make sure that the residents receive a therapeutic diet. Adequate documentation must be maintained. The resident also needs to be interviewed to determine food allergies and food preferences to ensure that the residents' needs are being met. The certified nursing assistant needs to accurately document the residents meal intake and update the nurse when there is a decrease noted in meal and fluid intake.

The Nutrition Assessment should include identification of the factors that put the resident at risk for malnutrition. The Nutritional Assessment may require a Registered Dietitian to assist. The healthcare team will need to review the factors that contributed to the decline, the potential for decline or the lack of improvement for residents who are

at risk. The medically related conditions and the nutritional problems need to be documented in the resident's care plan.

Some interventions may include:

Therapeutic diet
Altered fluid consistency
Altered texture of diet
Periodic review by the dietitian
Review of laboratory results
Special dinning program that encourage meal / fluid intake (restorative dining)

The problem and goals of the care plan is reviewed quarterly and with a significant change using the progress note or the reassessment form.

Documentation regarding Mental and Psychosocial Functioning

Based on the comprehensive assessment the facility must make sure that a resident, who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem. Some assessments used to identify mental and psychosocial functioning include, but not limited to:

Resident Assessment Instrument
Social History and Evaluation
Mini Mental State Exam (MMSE)
Neuropsychiatric Inventory (NPI)
Neuropsychological Tests
Clock Draw Test
ADAS-Cog (Alzheimer Disease Assessment Scale-Cognitive)
Behavioral Pathology in Alzheimer's Disease Rating Scale (BEHAVE-AD)
Cornell Depression Assessment

CERAD (The Consortium to Establish a Registry for Alzheimer's Disease) Clinical and
Cornell Scale for Depression in Dementia (CSDD)
Geriatric Depression Scale (GDS)
The 7 Minute Screen

Documentation regarding Restorative/Rehab Nursing Assessment

The long term care facility has to provide care and services to maintain or attain the resident's highest level of independent function. Based on the assessment the facility has to make sure that a resident who enters the facility without limited range of motion (ROM), functional activities of daily living does not experience a decline in their functional status unless the resident's clinical condition shows that it is unavoidable.

Assessments may include but not limited to:

The Resident Assessment Instrument
ADL assessments; bathing, grooming, hygiene, toileting, dressing
Screens and recommendations by physical therapist, occupational therapist and speech therapist,
Range of motion (ROM)
Bed mobility, ambulation and transfer
Self feeding ability
Bladder and/ or bowel status
Communication

Documentation within the care plan must include the functional deficit with measurable goals, and the restorative training program. The nurse who is in charge of the nursing restorative program needs to record progress notes that addresses the resident's progress toward goals. Many facilities ensure that documentation of the resident's progress is completed at least quarterly.

Documentation within the Care Plan

Documentation within the resident's care plan is critical to the resident's condition, needs and progress. The care plan has to provide direction to the healthcare team regarding providing care and treatment to the resident.

The facility has to develop a comprehensive care plan for every resident. The plan must include measurable objectives and time frames to meet the resident's nursing, medical, mental and psychosocial needs that have been identified in the comprehensive assessment.

The documentation within the care plan needs to describe the services that will be provided to maintain or attain the resident's highest possible physical, mental, psychosocial well-being; and any services that would otherwise be required but are not provided because the resident refused treatment etc.

The care plan must reflect steps for each outcome objectives if identification of those steps will enhance the resident's ability to meet his/her objectives. The healthcare team will use these objectives to monitor the resident's progress.

The care plan interventions need to be prioritized. This should be documented in the clinical record or on the plan of care. The care plan must be prepared by the interdisciplinary team which includes the physician, a nurse with the responsibility for the resident and other appropriate staff and disciplines as determined by the resident's needs, the participation of the resident, the resident's family or the resident's legal representative (if they would like to attend). There should be evidence/ documentation that the care plan is reviewed periodically by a team of qualified persons after each assessment and as the resident's status changes.

Documenting Skilled Nursing and Therapy services

The resident's medical record must have proof that the resident needed and have received skilled services such as nursing and / therapy services on a daily basis. The residents who are receiving skilled services have to show evidence in the medical record documentation of the need for daily skilled services that is being given. The content of the documentation needs to be objective and measurable.

When the therapy services are justifying the Medicare coverage, the nursing documentation should be consistent with the therapy documentation and address how skills the resident learned in therapy are being applied on the nursing unit.

Documentation regarding Activities of Daily Living (ADL)

Activities of daily living means functions and tasks for self-care, including ambulation, bathing, dressing, eating, grooming, toileting and other similar tasks. As the Certified Nursing Assistant documents, the documentation in the medical record should provide support for the scoring on the MDS along with observation and interviews. The facility needs to utilize ADL charting to collect information from all three shifts during the 7 day observation period. If the staff member assessing the ADL status and completing the MDS does not agree with the supporting documentation based on observations and / or interviews, a clarification note needs to be written documenting the reasons for the ADL scoring on the MDS.

ADL (Activities of Daily Living) Flow sheets and NAR (Nursing Assistant Record) Flow sheets

If the ADL flow sheets are used, it is best if they are tailored to the resident's care plan. ADL flow sheets can be either documented by nursing after consulting with direct care staff or by the certified nursing assistant providing the care. When the nursing assistant completes the flow sheets, there should be a system to monitor completion every shift. Unless you are using an electronic care tracking program, flow sheets are the easiest way to document amount of care rendered to the resident. ADL scores are critically important to scoring the ADL section of the MDS correctly. Scoring on the ADL

flow sheets should be consistent with the scoring on the MDS to increase consistency in data collection and assessment.

Rehabilitative Therapy Documentation

Rehabilitation Services are provided to improve the physical functioning of the resident, to allow them to return to the community. The Rehabilitation Services Assessment should be conducted within a reasonable timeframe after the physician's order is received. When the services have been started, a progress note needs to be documented within specific time lines; (some states within 14 days and then at least every 30 days as long as the resident is receiving therapy services).

The physician needs to certify the assessment and plan of care documented by the therapists. Within some facilities, the therapists utilize a specific government generated form for this purpose. The form may include:

- assessment of the resident's functional condition / status,
- the plan of care going forward and
- location for the physician's to sign, certifying the need for and approval of therapy services.

When the residents have reached their goal, a therapy discharge summary needs to be completed. The documentation must include the number of days and minutes of therapy. The clinical record needs to reflect the dates and times, usually documented in a flow record (electronic and /or hard copy). The therapists may include a notation regarding what the resident's performance level was for that therapy session and a weekly summary is often documented.

Nurse Practitioner (NP)/Physician Assistant (PA) Documentation

Federal regulations allow a nurse practitioner and Physician Assistant working with a physician to make every other required physician visit after the initial visit. The nurse practitioner and Physician Assistant needs to write a progress note at the time of the

visit. The federal regulations do not require countersignature by the attending physician; however, state law usually defines the nurse practitioner and Physician Assistant authority and should be reviewed to determine if the countersignatures are required. Federal regulations allow the physician and nurse practitioner to alternate the required visits, after the initial visit by the attending physician.

Physician Orders/ Admission Order

When a resident is admitted to the facility, the institution has to have physician orders for the resident's immediate care. These orders should include, at least, the resident's medications, diet and routine care to maintain or improve the resident's functional abilities until the healthcare worker/ staff can complete a comprehensive assessment and develop a comprehensive interdisciplinary plan of care. When the transfer orders are confirmed with the attending physician, the physician may add or delete some of the orders provided via the transfer document. These should be documented, as appropriate, following documentation standards.

Content of the Order

The physician's order should include the medication or treatment, the correlating reason or medical diagnosis. The medication order should include dosage, strength, the route of administration, frequency, and reason for administration should be documented in the order.

Telephone Orders

All orders that were received by telephone should be countersigned by the physician in the required timeframe as defined by state law. The documentation should indicate that the verbal order was read back and was verified with the physician. Follow your facility's policy regarding the appropriate timeframe for countersignature (some state may not indicate timeframe).

Standing Order

Standing orders have to be used with caution. Standing orders should not be used in place of notification to the physician of a change in status; the nurse has to update the physician with changes in resident's status. Some states do not allow the use of standing orders.

Transcription of Orders and Noting Orders

Transcription of orders, for example telephone orders, is the responsibility of the professional nurses (RN, LPN/LVN per the scope of practice defined by State law/practice acts), can also be delegated to a trained individual if allowed by state law or practice acts. If the transcription of order was delegated, the nurse still has to sign off on the order and retain the responsibility for accurate transcription. When the telephone order or fax order is transcribed into the resident's medical record, it should be transcribed/ documented "verbatim" as given from the physician.

Contacting the physician and obtaining the order

Nurses, Therapists and other professionals designated to take orders has to first contact the physician to obtain the order. Each resident's medical care has to be supervised by a licensed physician. Licensed nurses are not authorized to independently write the physician orders without first contacting the physician and receive direction of the physician. It is not acceptable to write the telephone order, implement the order and then send the order for signature without contacting the physician. The nurse practitioner and physician assistant has the authority by law and scope of practice to write orders on behalf of a physician.

Documentation regarding discontinuing an order when a new order is obtained

Accurate and complete documentation has to be complete when the physician changes a physician order that is currently in use. The original physician order must be discontinued first then the new order has to be written that reflects the change.

Accepting orders from a Nurse Practitioner (NP)/Physician Assistant (PA)

Orders should only be accepted from a nurse practitioner or physician assistant if the state practice acts allows the nurse practitioner or physician assistant to give orders or prescribe and the attending physician has given authorization through a scope of care agreement. Both the scope of care agreement with the attending physician and a copy of the nurse practitioner or physician assistant's license should be kept on file by the facility.

Documentation in the Medication and Treatment Records

Medication administration record (MAR) and treatment administration record (TAR) are derived from the physician orders. Nurses are required to document the delivery of medications and treatments, by placing their initials in the blocks of the MAR and TAR form when the medication or treatment has been administered. Some facility requires the initials to be circled if the medication or treatment was not administered / completed and to document the reason in the medical record, with appropriate to physician as needed. There should be no spaces or gaps noted in the Medication administration record (MAR) and treatment administration record documentation.
The medical record may also contain a legend that matches staff initials with full signature and title. Any medications and / or treatments given on a as needed (PRN) basis must be initialed, and the information pertaining to the need for the PRN, documented either on the back of the Medication administration record and treatment administration record or elsewhere in the resident's medical record as required by the facility's policy. For electronic records; the Medication and Treatment Records may only

have the initials on the Medication administration record and treatment administration record, either on print or view. Some electronic medication administration records (e-MARs) may be able to perform audit functions at the end of medication pass to make sure that all required documentation is in place.

Documentation regarding New Medication and Treatment Records on Readmission

Documentation of medications and treatments within the resident's medical record is crucial when the patient returns from another setting such as the hospital. To eliminate possible errors in transcription or administration of medications and treatments, new medication and treatment records should be initiated with a return from the hospital rather than continuing on the previous record. The new medication and treatment records would be based on the new orders received after hospitalization.

Documentation regarding Consents, Acknowledgements and Notices

Documentation must include an Informed Consent for the use of restraints
Check with your state regarding use of restraints. Within the long term care facility, when a restraint is being considered for a resident, the facility needs to obtain informed consent from the resident or from the resident's legal surrogate/representative. The facility has to explain the potential risks and benefits of using the restraint, the risks and benefits of not using a restraint, and alternatives to restraint all within the context of the resident's condition.

The informed consent should include:

- Explanation of how the restraint will treat the resident's medical symptoms,
- An explanation of how the restraint will assist the resident in maintaining and /or attaining his or her highest possible level of physical and/ or psychological well-being,
- An explanation of the negative outcomes of restraint use.

If the resident is not capable of making a decision, the legal representative or surrogate may exercise the right based on the information that would have been provided to the resident.

Documentation regarding Advance Directives

The facility has to inform all residents and provide written information to all residents concerning the right to accept or refuse medical or surgical treatment and the right to formulate an advance directive. A written description of the facility's policies to implement advanced directives and applicable state laws must be provided to the resident or the representative.

A copy of the advanced directive should be kept in the resident's medical record. Some states utilize the Physician Orders for Life Sustaining Treatment (POLST) or Medical Orders for Life Sustaining Treatment (MOLST) as the approved method for documenting the resident's wishes for treatment. The Physician Orders for Life-Sustaining Treatment is an approach to improving end-of-life care in the United States, encouraging physicians to speak with patients and create specific medical orders to be honored by health care workers during a medical crisis. The form is to be accepted by all health care providers.

Discharge Information

First there has to be a discharge order, the resident's physician must document that a discharge or transfer is necessary. This documentation is usually obtained by a physician order prior to transfer or discharge.

Discharge Documentation

A discharge narrative note should be written at the time of the resident's discharge and should include:

- The date of discharge,
- The time of discharge,
- The condition of the resident at discharge,
- The resident's disposition,
- The instructions, education/ training provided,
- Information regarding where the resident was discharged to, and
- The individual taking responsibility for the resident.

Discharge Summary Documentation

For the planned discharge such as discharge to another facility or to home, federal regulations require that the facility complete the discharge summary that includes:

- A concise summary of the resident's stay
- a final summary of the resident's status based on the comprehensive assessment, and
- A post discharge plan of care.

The post discharge plan of care will serve as the discharge instructions for a resident who is going home or as the transfer form for a resident going to the hospital or to another health care facility.

Content for the post discharge plan of care includes:

- A description of the resident and family's preference for care,
- how the resident and family will access the services, and
- how care should be coordinated if continuing treatment involves multiple care givers.
- Specific resident needs after discharge, such as personal care, sterile dressings, and therapy, as well as a description of resident/care giver education needs to enable the resident/care giver to meet needs after discharge.

Some facilities, depending on the policy will give a copy of the discharge summary to the resident when discharged from the facility.

Future Needs for Long Term Care

- By 2026, the population of Americans ages 65 and older will double to 71.5 million.
- Between 2007 and 2015, the number of Americans ages 85 and older is expected to increase by 40 percent.
- Among people turning 65 today, 69 percent will need some form of long-term care, whether in the community or in a residential care facility.
- By 2020, 12 million older Americans will need long term health care.

RESIDENTS' RIGHTS

Rights are often defined as legal, ethical or social principles of entitlement or freedom; which involves normative rules about what is allowed of people or what is owed to people or a legal or moral entitlement to obtain or have something or to act in a certain way.

Within the nursing home setting, residents' rights are the moral and legal rights of the residents of a nursing home. There are legislations that exist in various jurisdictions to help to protect such rights. In 1980 the Florida statute was enacted to protect such rights; Florida statute 400.022, commonly known as the Residents' Rights Act.

All individuals who work with residents must be aware of the rights of the resident, so that they can adhere to the legal /ethical principles, respect the residents' rights and also follow the standards of practice.

FLORIDA STATUTES 400.022 RESIDENTS' RIGHTS — NURSING HOMES AND RELATED HEALTH CARE FACILITIES states that:

(1) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:

(a) The right to civil and religious liberties, including knowledge of available choices and the right to independent personal decision, which will not be infringed upon, and the right to encouragement and assistance from the staff of the facility in the fullest possible exercise of these rights.

(b) The right to private and uncensored communication, including, but not limited to, receiving and sending unopened correspondence, access to a telephone, visiting with any person of the resident's choice during visiting hours, and overnight visitation outside the facility with family and friends in accordance with facility policies, physician orders, and Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act regulations, without the resident's losing his or her bed. Facility visiting hours shall be flexible, taking into consideration special circumstances such as, but not limited to, out-

of-town visitors and working relatives or friends. Unless otherwise indicated in the resident care plan, the licensee shall, with the consent of the resident and in accordance with policies approved by the agency, permit recognized volunteer groups, representatives of community-based legal, social, mental health, and leisure programs, and members of the clergy access to the facility during visiting hours for the purpose of visiting with and providing services to any resident.

(c) Any entity or individual that provides health, social, legal, or other services to a resident has the right to have reasonable access to the resident. The resident has the right to deny or withdraw consent to access at any time by any entity or individual. Notwithstanding the visiting policy of the facility, the following individuals must be permitted immediate access to the resident:

1. Any representative of the federal or state government, including, but not limited to, representatives of the Department of Children and Families, the Department of Health, the Agency for Health Care Administration, the Office of the Attorney General, and the Department of Elderly Affairs; any law enforcement officer; any representative of the State Long-Term Care Ombudsman Program; and the resident's individual physician.

2. Subject to the resident's right to deny or withdraw consent, immediate family or other relatives of the resident.

The facility must allow representatives of the State Long-Term Care Ombudsman Program to examine a resident's clinical records with the permission of the resident or the resident's legal representative and consistent with state law.
(d) The right to present grievances on behalf of himself or herself or others to the staff or administrator of the facility, to governmental officials, or to any other person; to recommend changes in policies and services to facility personnel; and to join with other residents or individuals within or outside the facility to work for improvements in resident care, free from restraint, interference, coercion, discrimination, or reprisal. This right includes access to ombudsmen and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. The right also includes the right to prompt efforts by the facility to resolve resident grievances, including grievances with respect to the behavior of other residents.

(e) The right to organize and participate in resident groups in the facility and the right to have the resident's family meet in the facility with the families of other residents.

(f) The right to participate in social, religious, and community activities that do not interfere with the rights of other residents.

(g) The right to examine, upon reasonable request, the results of the most recent inspection of the facility conducted by a federal or state agency and any plan of correction in effect with respect to the facility.

(h) The right to manage his or her own financial affairs or to delegate such responsibility to the licensee, but only to the extent of the funds held in trust by the licensee for the resident. A quarterly accounting of any transactions made on behalf of the resident shall be furnished to the resident or the person responsible for the resident. The facility may not require a resident to deposit personal funds with the facility. However, upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility as follows:

1. The facility must establish and maintain a system that ensures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

2. The accounting system established and maintained by the facility must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

3. A quarterly accounting of any transaction made on behalf of the resident shall be furnished to the resident or the person responsible for the resident.

4. Upon the death of a resident with personal funds deposited with the facility, the facility must convey within 30 days the resident's funds, including interest, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate, or, if a personal representative has not been appointed within 30 days, to the resident's spouse or adult next of kin named in the beneficiary designation form provided for in s. 400.162(6).

5.The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Title XVIII or Title XIX of the Social Security Act.

(i) The right to be fully informed, in writing and orally, prior to or at the time of admission and during his or her stay, of services available in the facility and of related charges for such services, including any charges for services not covered under Title XVIII or Title XIX of the Social Security Act or not covered by the basic per diem rates and of bed reservation and refund policies of the facility.

(j) The right to be adequately informed of his or her medical condition and proposed treatment, unless the resident is determined to be unable to provide informed consent under Florida law, or the right to be fully informed in advance of any nonemergency changes in care or treatment that may affect the resident's well-being; and, except with respect to a resident adjudged incompetent, the right to participate in the planning of all medical treatment, including the right to refuse medication and treatment, unless otherwise indicated by the resident's physician; and to know the consequences of such actions.

(k) The right to refuse medication or treatment and to be informed of the consequences of such decisions, unless determined unable to provide informed consent under state law. When the resident refuses medication or treatment, the nursing home facility must notify the resident or the resident's legal representative of the consequences of such decision and must document the resident's decision in his or her medical record. The nursing home facility must continue to provide other services the resident agrees to in accordance with the resident's care plan.

(l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.

(m) The right to have privacy in treatment and in caring for personal needs; to close room doors and to have facility personnel knock before entering the room, except in the case of an emergency or unless medically contraindicated; and to security in storing

and using personal possessions. Privacy of the resident's body shall be maintained during, but not limited to, toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. Residents' personal and medical records shall be confidential and exempt from the provisions of s. 119.07(1).

(n) The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and an oral explanation of the services provided by the licensee, including those required to be offered on an as-needed basis.

(o) The right to be free from mental and physical abuse, corporal punishment, extended involuntary seclusion, and from physical and chemical restraints, except those restraints authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, restraint may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of restraint and, in the case of use of a chemical restraint, a physician shall be consulted immediately thereafter. Restraints may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety.

(p) The right to be transferred or discharged only for medical reasons or for the welfare of other residents, and the right to be given reasonable advance notice of no less than 30 days of any involuntary transfer or discharge, except in the case of an emergency as determined by a licensed professional on the staff of the nursing home, or in the case of conflicting rules and regulations which govern Title XVIII or Title XIX of the Social Security Act. For nonpayment of a bill for care received, the resident shall be given 30 days' advance notice. A licensee certified to provide services under Title XIX of the Social Security Act may not transfer or discharge a resident solely because the source of payment for care changes. Admission to a nursing home facility operated by a licensee certified to provide services under Title XIX of the Social Security Act may not be conditioned upon a waiver of such right, and any document or provision in a document which purports to waive or preclude such right is void and unenforceable. Any licensee certified to provide services under Title XIX of the Social Security Act that obtains or attempts to obtain such a waiver from a resident or potential resident shall be construed to have violated the resident's rights as established herein and is subject to

disciplinary action as provided in subsection (3). The resident and the family or representative of the resident shall be consulted in choosing another facility.

(q) The right to freedom of choice in selecting a personal physician; to obtain pharmaceutical supplies and services from a pharmacy of the resident's choice, at the resident's own expense or through Title XIX of the Social Security Act; and to obtain information about, and to participate in, community-based activities programs, unless medically contraindicated as documented by a physician in the resident's medical record. If a resident chooses to use a community pharmacy and the facility in which the resident resides uses a unit-dose system, the pharmacy selected by the resident shall be one that provides a compatible unit-dose system, provides service delivery, and stocks the drugs normally used by long-term care residents. If a resident chooses to use a community pharmacy and the facility in which the resident resides does not use a unit-dose system, the pharmacy selected by the resident shall be one that provides service delivery and stocks the drugs normally used by long-term care residents.

(r) The right to retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other residents or unless medically contraindicated as documented in the resident's medical record by a physician. If clothing is provided to the resident by the licensee, it shall be of reasonable fit.

(s) The right to have copies of the rules and regulations of the facility and an explanation of the responsibility of the resident to obey all reasonable rules and regulations of the facility and to respect the personal rights and private property of the other residents.

(t) The right to receive notice before the room of the resident in the facility is changed.

(u) The right to be informed of the bed reservation policy for a hospitalization. The nursing home shall inform a private-pay resident and his or her responsible party that his or her bed will be reserved for any single hospitalization for a period up to 30 days provided the nursing home receives reimbursement. Any resident who is a recipient of assistance under Title XIX of the Social Security Act, or the resident's designee or legal representative, shall be informed by the licensee that his or her bed will be reserved for any single hospitalization for the length of time for which Title XIX reimbursement is available, up to 15 days; but that the bed will not be reserved if it is medically

determined by the agency that the resident will not need it or will not be able to return to the nursing home, or if the agency determines that the nursing home's occupancy rate ensures the availability of a bed for the resident. Notice shall be provided within 24 hours of the hospitalization.

(v) For residents of Medicaid or Medicare certified facilities, the right to challenge a decision by the facility to discharge or transfer the resident, as required under 42 C.F.R. s. 483.12.

(2) The licensee for each nursing home shall orally inform the resident of the resident's rights and provide a copy of the statement required by subsection (1) to each resident or the resident's legal representative at or before the resident's admission to a facility. The licensee shall provide a copy of the resident's rights to each staff member of the facility. Each such licensee shall prepare a written plan and provide appropriate staff training to implement the provisions of this section. The written statement of rights must include a statement that a resident may file a complaint with the agency or state or local ombudsman council. The statement must be in boldfaced type and include the telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the numbers of the local ombudsman council and the Elder Abuse Hotline operated by the Department of Children and Families.

(3) Any violation of the resident's rights set forth in this section constitutes grounds for action by the agency under s. 400.102, s. 400.121, or part II of chapter 408. In order to determine whether the licensee is adequately protecting residents' rights, the licensure inspection of the facility must include private informal conversations with a sample of residents to discuss residents' experiences within the facility with respect to rights specified in this section and general compliance with standards and consultation with the State Long-Term Care Ombudsman Program.

(4) Any person who submits or reports a complaint concerning a suspected violation of the resident's rights or concerning services or conditions in a facility or who testifies in any administrative or judicial proceeding arising from such complaint shall have immunity from any criminal or civil liability therefor, unless that person has acted in bad faith, with malicious purpose, or if the court finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party (See your state for more information).

All professionals have to make sure that they are aware of these rights and provide care / services to the clients/ patients, ensuring that the rights of the clients/ patients are being honored and there are no violations.

COMMUNICATION WITH CLIENTS/ PATIENTS, FAMILIES

Interpersonal skills are very important in establishing and maintaining an effective and productive and rewarding relationship with the clients/patients.

EFFECTIVE INTERPERSONAL RELATIONS

Effective interpersonal relationships involve:

Maintaining open communication,

Being a good listener

Being honest

Being sincere

Being courteous,

Being patient

Being hopeful.

Developing trusting and supportive relationships with clients/ patients by being trustworthy and supportive.

Encouraging clients/ patients to express their feelings.

Respect each client/ patient as a unique individual with their own behavior patterns.

APPROPRIATE STEPS TO STARTING A CONVERSATION

If the client/patient is in a private room with door closed, knock on the door before entering.

Identify yourself by name and title and greet client/ patient by their name.

Greet the client/patient in a courteous manner

Approach the client/patient in a calm manner.

Explain what you are going to do.

Explain the procedure to the client/ patient

Encourage the client/ patient to participate as needed.

SPEAKING/ ATTENTIVE LISTENING

It is recommended that you get the client's /patient's attention before speaking.

Always use courtesy when you are communicating.

Use normal tone of voice and adjust your volume to the individual client's/ patient's needs.

Listen and respond appropriately to the clients/ patients

Keep conversations brief and concise

Avoid using slang while communicating.

Speak slowly (avoid the rush tone)

Avoid mumbling and speak clearly

Employ positive messages by using praise, encouragement, smiles and other methods that are acceptable to the client/ patient.

Your verbal and nonverbal message should match

Be attentive and listen to what the client/ patient is saying.

Give/ receive feedback and/or request feedback as appropriate to make sure the communication is understood.

AVOID BARRIERS TO CONVERSATION

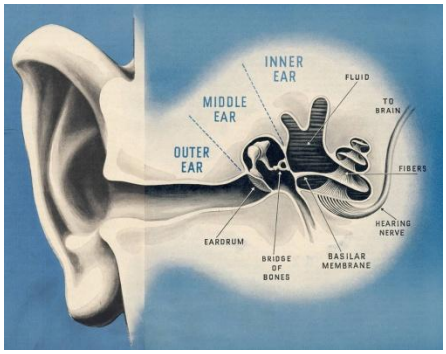
Avoid discussing or talking about your own personal problems and the problems of other patients or co-workers with the client/patient.

Avoid expressing your own opinions if it involves passing judgment

Avoid interrupting the clients/ patients when they are speaking

Avoid changing the subject.

COMMUNICATING WITH CLIENTS / PATIENTS WITH HEARING LOSS (HARD OF HEARING)



Avoid startling the client/ patient.

Stand comfortably close to the client/ patient in a good light and face him/her while you are speaking.

Speak at a normal or only slightly increased volume, so that you avoid shouting.

Write down key words if necessary or use other communication assistive devices such as communication boards if applicable.

Utilize short words and sentences.

Always clarify client's/ patient's understanding and rephrase message if applicable.

Eliminate as much as possible, any distracting background noise and /or activity.

Assist the client/ patient to use a hearing aid as applicable.

If the client/ patient hears better in one ear, then stand on the preferred side.

Speak slowly and distinctly/ clearly.

Avoid chewing gum or covering your face with your hands while speaking.

Avoid conveying negative messages by the tone of voice or even by your body language.

If the client/ patient use sign language, try to locate an individual who knows sign language to interpret.

COMMUNICATING WITH CLIENTS/ PATIENTS WITH LOSS OF VISION

Always identify self by name and title as you enter room to avoid startling the client/ patient.

Encourage and assist patient to keep glasses clean and to wear them (as applicable).

Ensure there is good light in the room and face client/ patient when you speak.

Speak in a normal tone of voice.

Give explanations of what you will be doing and what is expected of the client/ patient.

Clarify client/ patient's understanding as appropriate.

Remember not to rearrange the environment without the client's/ patient's knowledge.

If rearrangement is necessary, always replace items to their original location in the client's /patient's room.

Always inform the client/ patient when you are finished and when you are leaving.

COMMUNICATING WITH PATIENTS WHO HAVE PROBLEMS WITH SPEECH /SPEAKING

Try to keep conversation short as much as possible.

Ask direct questions if client/ patient can answer - Yes or No.

If you are unable to understand the words or uncertain, validate what you think the patient is saying.

Allow the client /patient adequate time to respond.

Employ attentive listening (listen carefully).

Emphasize positive aspects.

Take the time and complete every conversation, to avoid conveying any impatience.

Assist the client /patient to point, write or use assistive devices for communication for example word boards or picture board as appropriate.

Encourage the client /patient to nod as appropriate.

Monitor body language to make sure you are not giving negative messages.

NON-VERBAL COMMUNICATION

Non- verbal communication is also an important aspect of communication. Gestures, nodding of head, waving of hand all convey a message; therefore it is vital for the professionals to be aware that effective non-verbal communication is also needed while working with the clients/patients and other colleagues.

Non- verbal communication has several functions:

Non- verbal communication is sometimes a substitute for verbal message such as gestures or facial expressions.

Non- verbal communication is frequently used to accent verbal messages.

Non- verbal communication is sometimes used to repeat the verbal message for example pointing in a direction while giving directions.

Non- verbal communication often complements the verbal message.

Non- verbal communication often regulates interactions for example non-verbal cues may indicate when the other person should respond or not respond.

The Florida statutes 2016, chapter 400: NURSING HOMES AND RELATED HEALTH CARE FACILITIES

400.23 Rules; evaluation and deficiencies; licensure status

(1) It is the intent of the Legislature that rules published and enforced pursuant to this part and part II of chapter 408 shall include criteria by which a reasonable and consistent quality of resident care may be ensured and the results of such resident care can be demonstrated and by which safe and sanitary nursing homes can be provided. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a nursing home. In addition, efforts shall be made to minimize the paperwork associated with the reporting and documentation requirements of these rules.

(2) Pursuant to the intention of the Legislature, the agency, in consultation with the Department of Health and the Department of Elderly Affairs, shall adopt and enforce

rules to implement this part and part II of chapter 408, which shall include reasonable and fair criteria in relation to:

(a) The location of the facility and housing conditions that will ensure the health, safety, and comfort of residents, including an adequate call system. In making such rules, the agency shall be guided by criteria recommended by nationally recognized reputable professional groups and associations with knowledge of such subject matters. The agency shall update or revise such criteria as the need arises. The agency may require alterations to a building if it determines that an existing condition constitutes a distinct hazard to life, health, or safety. In performing any inspections of facilities authorized by this part or part II of chapter 408, the agency may enforce the special-occupancy provisions of the Florida Building Code and the Florida Fire Prevention Code which apply to nursing homes. Residents or their representatives shall be able to request a change in the placement of the bed in their room, provided that at admission they are presented with a room that meets requirements of the Florida Building Code. The location of a bed may be changed if the requested placement does not infringe on the resident's roommate or interfere with the resident's care or safety as determined by the care planning team in accordance with facility policies and procedures. In addition, the bed placement may not be used as a restraint. Each facility shall maintain a log of resident rooms with beds that are not in strict compliance with the Florida Building Code in order for such log to be used by surveyors and nurse monitors during inspections and visits. A resident or resident representative who requests that a bed be moved shall sign a statement indicating that he or she understands the room will not be in compliance with the Florida Building Code, but they would prefer to exercise their right to self-determination. The statement must be retained as part of the resident's care plan. Any facility that offers this option must submit a letter signed by the nursing home administrator of record to the agency notifying it of this practice with a copy of the policies and procedures of the facility. The agency is directed to provide assistance to the Florida Building Commission in updating the construction standards of the code relative to nursing homes.

(b) The number and qualifications of all personnel, including management, medical, nursing, and other professional personnel, and nursing assistants, orderlies, and support personnel, having responsibility for any part of the care given residents.

(c) All sanitary conditions within the facility and its surroundings, including water supply, sewage disposal, food handling, and general hygiene which will ensure the health and comfort of residents.

(d) The equipment essential to the health and welfare of the residents.

(e) A uniform accounting system.

(f) The care, treatment, and maintenance of residents and measurement of the quality and adequacy thereof, based on rules developed under this chapter and the Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 100-203) (December 22, 1987), Title IV (Medicare, Medicaid, and Other Health-Related Programs), Subtitle C (Nursing Home Reform), as amended.

(g) The preparation and annual update of a comprehensive emergency management plan. The agency shall adopt rules establishing minimum criteria for the plan after consultation with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records; and responding to family inquiries. The comprehensive emergency management plan is subject to review and approval by the local emergency management agency. During its review, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elderly Affairs, the Department of Health, the Agency for Health Care Administration, and the Division of Emergency Management. Also, appropriate volunteer organizations must be given the opportunity to review the plan. The local emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions.

(h) The availability, distribution, and posting of reports and records pursuant to s. 400.191 and the Gold Seal Program pursuant to s. 400.235.

(3)(a)1. The agency shall adopt rules providing minimum staffing requirements for nursing home facilities. These requirements must include, for each facility:

a. A minimum weekly average of certified nursing assistant and licensed nursing staffing combined of 3.6 hours of direct care per resident per day. As used in this sub-subparagraph, a week is defined as Sunday through Saturday.

b. A minimum certified nursing assistant staffing of 2.5 hours of direct care per resident per day. A facility may not staff below one certified nursing assistant per 20 residents.

c. A minimum licensed nursing staffing of 1.0 hour of direct care per resident per day. A facility may not staff below one licensed nurse per 40 residents.

2. Nursing assistants employed under s. 400.211(2) may be included in computing the staffing ratio for certified nursing assistants if their job responsibilities include only nursing-assistant-related duties.

3. Each nursing home facility must document compliance with staffing standards as required under this paragraph and post daily the names of staff on duty for the benefit of facility residents and the public.

4. The agency shall recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants if the nursing home facility otherwise meets the minimum staffing requirements for licensed nurses and the licensed nurses are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted toward the minimum staffing requirements for certified nursing assistants must exclusively perform the duties of a certified nursing assistant for the entire shift and not also be counted toward the minimum staffing requirements for licensed nurses. If the agency approved a facility's request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically spent on certified nursing assistant duties for the purpose of documenting compliance with

minimum staffing requirements for certified and licensed nursing staff. The hours of a licensed nurse with dual job responsibilities may not be counted twice.

(b) Nonnursing staff providing eating assistance to residents shall not count toward compliance with minimum staffing standards.

(c) Licensed practical nurses licensed under chapter 464 who are providing nursing services in nursing home facilities under this part may supervise the activities of other licensed practical nurses, certified nursing assistants, and other unlicensed personnel providing services in such facilities in accordance with rules adopted by the Board of Nursing.

(4) Rules developed pursuant to this section shall not restrict the use of shared staffing and shared programming in facilities which are part of retirement communities that provide multiple levels of care and otherwise meet the requirement of law or rule.

(5) The agency, in collaboration with the Division of Children's Medical Services of the Department of Health, must adopt rules for:

(a) Minimum standards of care for persons under 21 years of age who reside in nursing home facilities. A facility may be exempted from these standards for specific persons between 18 and 21 years of age, if the person's physician agrees that minimum standards of care based on age are not necessary.

(b) Minimum staffing requirements for persons under 21 years of age who reside in nursing home facilities, which apply in lieu of the requirements contained in subsection (3).

1. For persons under 21 years of age who require skilled care:

a. A minimum combined average of 3.9 hours of direct care per resident per day must be provided by licensed nurses, respiratory therapists, respiratory care practitioners, and certified nursing assistants.

b. A minimum licensed nursing staffing of 1.0 hour of direct care per resident per day must be provided.

c. No more than 1.5 hours of certified nursing assistant care per resident per day may be counted in determining the minimum direct care hours required.

d. One registered nurse must be on duty on the site 24 hours per day on the unit where children reside.

2. For persons under 21 years of age who are medically fragile:

a. A minimum combined average of 5.0 hours of direct care per resident per day must be provided by licensed nurses, respiratory therapists, respiratory care practitioners, and certified nursing assistants.

b. A minimum licensed nursing staffing of 1.7 hours of direct care per resident per day must be provided.

c. No more than 1.5 hours of certified nursing assistant care per resident per day may be counted in determining the minimum direct care hours required.

d. One registered nurse must be on duty on the site 24 hours per day on the unit where children reside.

(6) Before conducting a survey of the facility, the survey team shall obtain a copy of the local long-term care ombudsman council report on the facility. Problems noted in the report shall be incorporated into and followed up through the agency's inspection process. This procedure does not preclude the State Long-Term Care Ombudsman Program or local long-term care ombudsman council from requesting the agency to conduct a followup visit to the facility.

(7) The agency shall, at least every 15 months, evaluate all nursing home facilities and make a determination as to the degree of compliance by each licensee with the established rules adopted under this part as a basis for assigning a licensure status to that facility. The agency shall base its evaluation on the most recent inspection report, taking into consideration findings from other official reports, surveys, interviews, investigations, and inspections. In addition to license categories authorized under part II of chapter 408, the agency shall assign a licensure status of standard or conditional to each nursing home.

(a) A standard licensure status means that a facility has no class I or class II deficiencies and has corrected all class III deficiencies within the time established by the agency.

(b) A conditional licensure status means that a facility, due to the presence of one or more class I or class II deficiencies, or class III deficiencies not corrected within the time established by the agency, is not in substantial compliance at the time of the survey with criteria established under this part or with rules adopted by the agency. If the facility has no class I, class II, or class III deficiencies at the time of the followup survey, a standard licensure status may be assigned.

(c) In evaluating the overall quality of care and services and determining whether the facility will receive a conditional or standard license, the agency shall consider the needs and limitations of residents in the facility and the results of interviews and surveys of a representative sampling of residents, families of residents, representatives of the State Long-Term Care Ombudsman Program, guardians of residents, and staff of the nursing home facility.

(d) The current licensure status of each facility must be indicated in bold print on the face of the license. A list of the deficiencies of the facility shall be posted in a prominent place that is in clear and unobstructed public view at or near the place where residents are being admitted to that facility. Licensees receiving a conditional licensure status for a facility shall prepare, within 10 working days after receiving notice of deficiencies, a plan for correction of all deficiencies and shall submit the plan to the agency for approval.

(e) The agency shall adopt rules that:

1. Establish uniform procedures for the evaluation of facilities.

2. Provide criteria in the areas referenced in paragraph (c).

3. Address other areas necessary for carrying out the intent of this section.

(8) The agency shall adopt rules pursuant to this part and part II of chapter 408 to provide that, when the criteria established under subsection (2) are not met, such deficiencies shall be classified according to the nature and the scope of the deficiency.

The scope shall be cited as isolated, patterned, or widespread. An isolated deficiency is a deficiency affecting one or a very limited number of residents, or involving one or a very limited number of staff, or a situation that occurred only occasionally or in a very limited number of locations. A patterned deficiency is a deficiency where more than a very limited number of residents are affected, or more than a very limited number of staff are involved, or the situation has occurred in several locations, or the same resident or residents have been affected by repeated occurrences of the same deficient practice but the effect of the deficient practice is not found to be pervasive throughout the facility. A widespread deficiency is a deficiency in which the problems causing the deficiency are pervasive in the facility or represent systemic failure that has affected or has the potential to affect a large portion of the facility's residents. The agency shall indicate the classification on the face of the notice of deficiencies as follows:

(a) A class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility. The condition or practice constituting a class I violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the agency, is required for correction. A class I deficiency is subject to a civil penalty of $10,000 for an isolated deficiency, $12,500 for a patterned deficiency, and $15,000 for a widespread deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last licensure inspection or any inspection or complaint investigation since the last licensure inspection. A fine must be levied notwithstanding the correction of the deficiency.

(b) A class II deficiency is a deficiency that the agency determines has compromised the resident's ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. A class II deficiency is subject to a civil penalty of $2,500 for an isolated deficiency, $5,000 for a patterned deficiency, and $7,500 for a widespread deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last licensure inspection or any inspection or complaint

investigation since the last licensure inspection. A fine shall be levied notwithstanding the correction of the deficiency.

(c) A class III deficiency is a deficiency that the agency determines will result in no more than minimal physical, mental, or psychosocial discomfort to the resident or has the potential to compromise the resident's ability to maintain or reach his or her highest practical physical, mental, or psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. A class III deficiency is subject to a civil penalty of $1,000 for an isolated deficiency, $2,000 for a patterned deficiency, and $3,000 for a widespread deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last licensure inspection or any inspection or complaint investigation since the last licensure inspection. A citation for a class III deficiency must specify the time within which the deficiency is required to be corrected. If a class III deficiency is corrected within the time specified, a civil penalty may not be imposed.

(d) A class IV deficiency is a deficiency that the agency determines has the potential for causing no more than a minor negative impact on the resident. If the class IV deficiency is isolated, no plan of correction is required.

(9) Civil penalties paid by any licensee under subsection (8) shall be deposited in the Health Care Trust Fund and expended as provided in s. 400.063.

(10) Agency records, reports, ranking systems, Internet information, and publications must be promptly updated to reflect the most current agency actions.

Chapter 464.003, F.S

(16) “Licensed practical nurse” means any person licensed in this state to practice practical nursing.

(17) “Nursing diagnosis” means the observation and evaluation of physical or mental conditions, behaviors, signs and symptoms of illness, and reactions to treatment and the determination as to whether such conditions, signs, symptoms, and reactions represent a deviation from normal.

(18) “Nursing treatment” means the establishment and implementation of a nursing regimen for the care and comfort of individuals, the prevention of illness, and the education, restoration, and maintenance of health.

(19) “Practice of practical nursing” means the performance of selected acts, including the administration of treatments and medications, in the care of the ill, injured, or infirm; the promotion of wellness, maintenance of health, and prevention of illness of others under the direction of a registered nurse, a licensed physician, a licensed osteopathic physician, a licensed podiatric physician, or a licensed dentist; and the teaching of general principles of health and wellness to the public and to students other than nursing students. A practical nurse is responsible and accountable for making decisions that are based upon the individual’s educational preparation and experience in nursing.

(20) “Practice of professional nursing” means the performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principles of psychological, biological, physical, and social sciences which shall include, but not be limited to:

(a) The observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care; health teaching and counseling of the ill, injured, or infirm; and the promotion of wellness, maintenance of health, and prevention of illness of others.

(b) The administration of medications and treatments as prescribed or authorized by a duly licensed practitioner authorized by the laws of this state to prescribe such medications and treatments.

(c) The supervision and teaching of other personnel in the theory and performance of any of the acts described in this subsection.

A professional nurse is responsible and accountable for making decisions that are based upon the individual's educational preparation and experience in nursing.

Chapter 464, F.S

464.018 DISCIPLINARY ACTIONS

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(a) Procuring, attempting to procure, or renewing a license to practice nursing by bribery, by knowing misrepresentations, or through an error of the department or the board.

(b) Having a license to practice nursing revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of another state, territory, or country.

(c) Being convicted or found guilty of, or entering a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction which directly relates to the practice of nursing or to the ability to practice nursing.

(d) Being found guilty, regardless of adjudication, of any of the following offenses:

1. A forcible felony as defined in chapter 776.
2. A violation of chapter 812, relating to theft, robbery, and related crimes.
3. A violation of chapter 817, relating to fraudulent practices.
4. A violation of chapter 800, relating to lewdness and indecent exposure.
5. A violation of chapter 784, relating to assault, battery, and culpable negligence.
6. A violation of chapter 827, relating to child abuse.
7. A violation of chapter 415, relating to protection from abuse, neglect, and exploitation.
8. A violation of chapter 39, relating to child abuse, abandonment, and neglect.

(e) Having been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under s. 435.04 or similar statute of another jurisdiction; or having committed an act which constitutes domestic violence as defined in s. 741.28.

(f) Making or filing a false report or record, which the licensee knows to be false, intentionally or negligently failing to file a report or record required by state or federal law, willfully impeding or obstructing such filing or inducing another person to do so. Such reports or records shall include only those which are signed in the nurse's capacity as a licensed nurse.

(g) False, misleading, or deceptive advertising.

(h) Unprofessional conduct, as defined by board rule.

(i) Engaging or attempting to engage in the possession, sale, or distribution of controlled substances as set forth in chapter 893, for any other than legitimate purposes authorized by this part.

(j) Being unable to practice nursing with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, or chemicals or any other type of material or as a result of any mental or physical condition. In enforcing this paragraph, the department shall have, upon a finding of the State Surgeon General or the State Surgeon General's designee that probable cause exists to believe that the licensee is unable to practice nursing because of the reasons stated in this paragraph, the authority to issue an order to compel a licensee to submit to a mental or physical examination by physicians designated by the department. If the licensee refuses to comply with such order, the department's order directing such examination may be enforced by filing a petition for enforcement in the circuit court where the licensee resides or does business. The licensee against whom the petition is filed shall not be named or identified by initials in any public court records or documents, and the proceedings shall be closed to the public. The department shall be entitled to the summary procedure provided in s. 51.011. A nurse affected by the provisions of this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate that she or he can resume the competent practice of nursing with reasonable skill and safety to patients.

(k) Failing to report to the department any person who the licensee knows is in violation of this part or of the rules of the department or the board; however, if the licensee verifies that such person is actively participating in a board-approved program for the treatment of a physical or mental condition, the licensee is required to report such person only to an impaired professionals consultant.

(l) Knowingly violating any provision of this part, a rule of the board or the department, or a lawful order of the board or department previously entered in a

disciplinary proceeding or failing to comply with a lawfully issued subpoena of the department.

(m) Failing to report to the department any licensee under chapter 458 or under chapter 459 who the nurse knows has violated the grounds for disciplinary action set out in the law under which that person is licensed and who provides health care services in a facility licensed under chapter 395, or a health maintenance organization certificated under part I of chapter 641, in which the nurse also provides services.

(n) Failing to meet minimal standards of acceptable and prevailing nursing practice, including engaging in acts for which the licensee is not qualified by training or experience.

(o) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

(p) For an advanced registered nurse practitioner:

1. Presigning blank prescription forms.

2. Prescribing for office use any medicinal drug appearing on Schedule II in chapter 893.

3. Prescribing, ordering, dispensing, administering, supplying, selling, or giving a drug that is an amphetamine, a sympathomimetic amine drug, or a compound designated in s. 893.03(2) as a Schedule II controlled substance, to or for any person except for:

a. The treatment of narcolepsy; hyperkinesis; behavioral syndrome in children characterized by the developmentally inappropriate symptoms of moderate to severe distractibility, short attention span, hyperactivity, emotional lability, and impulsivity; or drug-induced brain dysfunction.

b. The differential diagnostic psychiatric evaluation of depression or the treatment of depression shown to be refractory to other therapeutic modalities.

c. The clinical investigation of the effects of such drugs or compounds when an investigative protocol is submitted to, reviewed by, and approved by the department before such investigation is begun.

4. Prescribing, ordering, dispensing, administering, supplying, selling, or giving growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG), or other hormones for the purpose of muscle building or to enhance athletic performance. As used in this subparagraph, the term “muscle building” does not include the treatment of injured muscle. A prescription written for the drug products identified in this

subparagraph may be dispensed by a pharmacist with the presumption that the prescription is for legitimate medical use.

5. Promoting or advertising on any prescription form a community pharmacy unless the form also states: “This prescription may be filled at any pharmacy of your choice.”

6. Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including a controlled substance, other than in the course of his or her professional practice. For the purposes of this subparagraph, it is legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the advanced registered nurse practitioner’s professional practice, without regard to his or her intent.

7. Prescribing, dispensing, or administering a medicinal drug appearing on any schedule set forth in chapter 893 to himself or herself, except a drug prescribed, dispensed, or administered to the advanced registered nurse practitioner by another practitioner authorized to prescribe, dispense, or administer medicinal drugs.

8. Prescribing, ordering, dispensing, administering, supplying, selling, or giving amygdalin (laetrile) to any person.

9. Dispensing a substance designated in s. 893.03(2) or (3) as a substance controlled in Schedule II or Schedule III, respectively, in violation of s. 465.0276.

10. Promoting or advertising through any communication medium the use, sale, or dispensing of a substance designated in s. 893.03 as a controlled substance.

(q) For a psychiatric nurse:

1. Presigning blank prescription forms.

2. Prescribing for office use any medicinal drug appearing in Schedule II of s. 893.03.

3. Prescribing, ordering, dispensing, administering, supplying, selling, or giving a drug that is an amphetamine, a sympathomimetic amine drug, or a compound designated in s. 893.03(2) as a Schedule II controlled substance, to or for any person except for:

a. The treatment of narcolepsy; hyperkinesis; behavioral syndrome in children characterized by the developmentally inappropriate symptoms of moderate to severe distractibility, short attention span, hyperactivity, emotional lability, and impulsivity; or drug-induced brain dysfunction.

b. The differential diagnostic psychiatric evaluation of depression or the treatment of depression shown to be refractory to other therapeutic modalities.

c. The clinical investigation of the effects of such drugs or compounds when an investigative protocol is submitted to, reviewed by, and approved by the department before such investigation is begun.

4. Prescribing, ordering, dispensing, administering, supplying, selling, or giving growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG), or other hormones for the purpose of muscle building or to enhance athletic performance. As used in this subparagraph, the term “muscle building” does not include the treatment of injured muscle. A prescription written for the drug products identified in this subparagraph may be dispensed by a pharmacist with the presumption that the prescription is for legitimate medical use.

5. Promoting or advertising on any prescription form a community pharmacy unless the form also states: “This prescription may be filled at any pharmacy of your choice.”

6. Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including a controlled substance, other than in the course of his or her professional practice. For the purposes of this subparagraph, it is legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the advanced registered nurse practitioner’s professional practice, without regard to his or her intent.

7. Prescribing, dispensing, or administering a medicinal drug appearing on any schedule set forth in chapter 893 to himself or herself, except a drug prescribed, dispensed, or administered to the psychiatric nurse by another practitioner authorized to prescribe, dispense, or administer medicinal drugs.

8. Prescribing, ordering, dispensing, administering, supplying, selling, or giving amygdalin (laetrile) to any person.

9. Dispensing a substance designated in s. 893.03(2) or (3) as a substance controlled in Schedule II or Schedule III, respectively, in violation of s. 465.0276.

10. Promoting or advertising through any communication medium the use, sale, or dispensing of a substance designated in s. 893.03 as a controlled substance.

[1](2) The board may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found

guilty of violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s. 456.072(1).

(3) The board shall not reinstate the license of a nurse, or cause a license to be issued to a person it has deemed unqualified, until such time as it is satisfied that such person has complied with all the terms and conditions set forth in the final order and that such person is capable of safely engaging in the practice of nursing.

(4) The board shall not reinstate the license of a nurse who has been found guilty by the board on three separate occasions of violations of this part relating to the use of drugs or narcotics, which offenses involved the diversion of drugs or narcotics from patients to personal use or sale.

(5) The board shall by rule establish guidelines for the disposition of disciplinary cases involving specific types of violations. Such guidelines may include minimum and maximum fines, periods of supervision or probation, or conditions of probation or reissuance of a license.

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in ss. 456.072(2) and 464.0095:

(a) Procuring, attempting to procure, or renewing a license to practice nursing or the authority to practice practical or professional nursing pursuant to s. 464.0095 by bribery, by knowing misrepresentations, or through an error of the department or the board.

(b) Having a license to practice nursing revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of another state, territory, or country.

(c) Being convicted or found guilty of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which directly relates to the practice of nursing or to the ability to practice nursing.

(d) Being convicted or found guilty of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, any of the following offenses:

1. A forcible felony as defined in chapter 776.
2. A violation of chapter 812, relating to theft, robbery, and related crimes.
3. A violation of chapter 817, relating to fraudulent practices.
4. A violation of chapter 800, relating to lewdness and indecent exposure.
5. A violation of chapter 784, relating to assault, battery, and culpable negligence.

6. A violation of chapter 827, relating to child abuse.

7. A violation of chapter 415, relating to protection from abuse, neglect, and exploitation.

8. A violation of chapter 39, relating to child abuse, abandonment, and neglect.

9. For an applicant for a multistate license or for a multistate licenseholder under s. 464.0095, a felony offense under Florida law or federal criminal law.

(e) Having been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under s. 435.04 or similar statute of another jurisdiction; or having committed an act which constitutes domestic violence as defined in s. 741.28.

(f) Making or filing a false report or record, which the nurse knows to be false, intentionally or negligently failing to file a report or record required by state or federal law, willfully impeding or obstructing such filing or inducing another person to do so. Such reports or records shall include only those which are signed in the nurse's capacity as a licensed nurse.

(g) False, misleading, or deceptive advertising.

(h) Unprofessional conduct, as defined by board rule.

(i) Engaging or attempting to engage in the possession, sale, or distribution of controlled substances as set forth in chapter 893, for any other than legitimate purposes authorized by this part.

(j) Being unable to practice nursing with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, or chemicals or any other type of material or as a result of any mental or physical condition. In enforcing this paragraph, the department shall have, upon a finding of the State Surgeon General or the State Surgeon General's designee that probable cause exists to believe that the nurse is unable to practice nursing because of the reasons stated in this paragraph, the authority to issue an order to compel a nurse to submit to a mental or physical examination by physicians designated by the department. If the nurse refuses to comply with such order, the department's order directing such examination may be enforced by filing a petition for enforcement in the circuit court where the nurse resides or does business. The nurse against whom the petition is filed shall not be named or identified by initials in any public court records or documents, and the proceedings shall be closed to the public. The department shall be entitled to the summary procedure provided in s. 51.011. A nurse affected by this paragraph shall at reasonable intervals be afforded an

opportunity to demonstrate that she or he can resume the competent practice of nursing with reasonable skill and safety to patients.

(k) Failing to report to the department any person who the nurse knows is in violation of this part or of the rules of the department or the board; however, if the nurse verifies that such person is actively participating in a board-approved program for the treatment of a physical or mental condition, the nurse is required to report such person only to an impaired professionals consultant.

(l) Knowingly violating any provision of this part, a rule of the board or the department, or a lawful order of the board or department previously entered in a disciplinary proceeding or failing to comply with a lawfully issued subpoena of the department.

(m) Failing to report to the department any licensee under chapter 458 or under chapter 459 who the nurse knows has violated the grounds for disciplinary action set out in the law under which that person is licensed and who provides health care services in a facility licensed under chapter 395, or a health maintenance organization certificated under part I of chapter 641, in which the nurse also provides services.

(n) Failing to meet minimal standards of acceptable and prevailing nursing practice, including engaging in acts for which the nurse is not qualified by training or experience.

(o) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

(p) For an advanced registered nurse practitioner:

1. Presigning blank prescription forms.

2. Prescribing for office use any medicinal drug appearing on Schedule II in chapter 893.

3. Prescribing, ordering, dispensing, administering, supplying, selling, or giving a drug that is an amphetamine, a sympathomimetic amine drug, or a compound designated in s. 893.03(2) as a Schedule II controlled substance, to or for any person except for:

a. The treatment of narcolepsy; hyperkinesis; behavioral syndrome in children characterized by the developmentally inappropriate symptoms of moderate to severe distractibility, short attention span, hyperactivity, emotional lability, and impulsivity; or drug-induced brain dysfunction.

b. The differential diagnostic psychiatric evaluation of depression or the treatment of depression shown to be refractory to other therapeutic modalities.

c. The clinical investigation of the effects of such drugs or compounds when an investigative protocol is submitted to, reviewed by, and approved by the department before such investigation is begun.

4. Prescribing, ordering, dispensing, administering, supplying, selling, or giving growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG), or other hormones for the purpose of muscle building or to enhance athletic performance. As used in this subparagraph, the term “muscle building” does not include the treatment of injured muscle. A prescription written for the drug products identified in this subparagraph may be dispensed by a pharmacist with the presumption that the prescription is for legitimate medical use.

5. Promoting or advertising on any prescription form a community pharmacy unless the form also states: “This prescription may be filled at any pharmacy of your choice.”

6. Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including a controlled substance, other than in the course of his or her professional practice. For the purposes of this subparagraph, it is legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the advanced registered nurse practitioner’s professional practice, without regard to his or her intent.

7. Prescribing, dispensing, or administering a medicinal drug appearing on any schedule set forth in chapter 893 to himself or herself, except a drug prescribed, dispensed, or administered to the advanced registered nurse practitioner by another practitioner authorized to prescribe, dispense, or administer medicinal drugs.

8. Prescribing, ordering, dispensing, administering, supplying, selling, or giving amygdalin (laetrile) to any person.

9. Dispensing a substance designated in s. 893.03(2) or (3) as a substance controlled in Schedule II or Schedule III, respectively, in violation of s. 465.0276.

10. Promoting or advertising through any communication medium the use, sale, or dispensing of a substance designated in s. 893.03 as a controlled substance.

(q) For a psychiatric nurse:

1. Presigning blank prescription forms.

2. Prescribing for office use any medicinal drug appearing in Schedule II of s. 893.03.

3. Prescribing, ordering, dispensing, administering, supplying, selling, or giving a drug that is an amphetamine, a sympathomimetic amine drug, or a compound designated in s. 893.03(2) as a Schedule II controlled substance, to or for any person except for:

a. The treatment of narcolepsy; hyperkinesis; behavioral syndrome in children characterized by the developmentally inappropriate symptoms of moderate to severe distractibility, short attention span, hyperactivity, emotional lability, and impulsivity; or drug-induced brain dysfunction.

b. The differential diagnostic psychiatric evaluation of depression or the treatment of depression shown to be refractory to other therapeutic modalities.

c. The clinical investigation of the effects of such drugs or compounds when an investigative protocol is submitted to, reviewed by, and approved by the department before such investigation is begun.

4. Prescribing, ordering, dispensing, administering, supplying, selling, or giving growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG), or other hormones for the purpose of muscle building or to enhance athletic performance. As used in this subparagraph, the term “muscle building” does not include the treatment of injured muscle. A prescription written for the drug products identified in this subparagraph may be dispensed by a pharmacist with the presumption that the prescription is for legitimate medical use.

5. Promoting or advertising on any prescription form a community pharmacy unless the form also states: “This prescription may be filled at any pharmacy of your choice.”

6. Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including a controlled substance, other than in the course of his or her professional practice. For the purposes of this subparagraph, it is legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the advanced registered nurse practitioner’s professional practice, without regard to his or her intent.

7. Prescribing, dispensing, or administering a medicinal drug appearing on any schedule set forth in chapter 893 to himself or herself, except a drug prescribed, dispensed, or administered to the psychiatric nurse by another practitioner authorized to prescribe, dispense, or administer medicinal drugs.

8. Prescribing, ordering, dispensing, administering, supplying, selling, or giving amygdalin (laetrile) to any person.

9. Dispensing a substance designated in s. 893.03(2) or (3) as a substance controlled in Schedule II or Schedule III, respectively, in violation of s. 465.0276.

10. Promoting or advertising through any communication medium the use, sale, or dispensing of a substance designated in s. 893.03 as a controlled substance.

(2)(a) The board may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or nurse who is found guilty of violating subsection (1) or s. 456.072(1).

(b) The board may take adverse action against a nurse's multistate licensure privilege and impose any of the penalties in s. 456.072(2) when the nurse is found guilty of violating subsection (1) or s. 456.072(1).

CERTIFIED NURSING ASSISTANTS

464.201 Definitions.
464.202 Duties and powers of the board.
464.203 Certified nursing assistants; certification requirement.
464.204 Denial, suspension, or revocation of certification; disciplinary actions.
464.205 Availability of disciplinary records and proceedings.
464.206 Exemption from liability.
464.207 Penalties.
464.208 Background screening information; rulemaking authority.

464.201 Definitions as used in this part, the term:

(1) "Approved training program" means:

(a) A course of training conducted by a public sector or private sector educational center licensed by the Department of Education to implement the basic curriculum for nursing assistants which is approved by the Department of Education. Beginning October 1, 2000, the board shall assume responsibility for approval of training programs under this paragraph.

(b) A training program operated under s. 400.141.

(2) “Board” means the Board of Nursing.

(3) “Certified nursing assistant” means a person who meets the qualifications specified in this part and who is certified by the board as a certified nursing assistant.

(4) “Department” means the Department of Health.

(5) “Practice of a certified nursing assistant” means providing care and assisting persons with tasks relating to the activities of daily living. Such tasks are those associated with personal care, maintaining mobility, nutrition and hydration, toileting and elimination, assistive devices, safety and cleanliness, data gathering, reporting abnormal signs and symptoms, postmortem care, patient socialization and reality orientation, end-of-life care, cardiopulmonary resuscitation and emergency care, residents’ or patients’ rights, documentation of nursing-assistant services, and other tasks that a certified nurse assistant may perform after training beyond that required for initial certification and upon validation of competence in that skill by a registered nurse. This subsection does not restrict the ability of any person who is otherwise trained and educated from performing such tasks.

(6) “Registry” means the listing of certified nursing assistants maintained by the board.

464.202 Duties and powers of the board

The board shall maintain, or contract with or approve another entity to maintain, a state registry of certified nursing assistants. The registry must consist of the name of each certified nursing assistant in this state; other identifying information defined by board rule; certification status; the effective date of certification; other information required by state or federal law; information regarding any crime or any abuse, neglect, or exploitation as provided under chapter 435; and any disciplinary action taken against the certified nursing assistant. The registry shall be accessible to the public, the certificate holder, employers, and other state agencies. The board shall adopt by rule testing procedures for use in certifying nursing assistants and shall adopt rules regulating the practice of certified nursing assistants and specifying the scope of practice authorized and the level of supervision required for the practice of certified nursing assistants. The board may contract with or approve another entity or organization to provide the examination services, including the development and administration of examinations. The board shall require that the contract provider offer certified nursing assistant applications via the Internet, and may require the contract provider to accept certified nursing assistant applications for processing via the Internet.

The board shall require the contract provider to provide the preliminary results of the certified nursing examination on the date the test is administered. The provider shall pay all reasonable costs and expenses incurred by the board in evaluating the provider's application and performance during the delivery of services, including examination services and procedures for maintaining the certified nursing assistant registry.

464.203 Certified nursing assistants; certification requirement:

(1) The board shall issue a certificate to practice as a certified nursing assistant to any person who demonstrates a minimum competency to read and write and successfully passes the required background screening pursuant to s. 400.215. If the person has successfully passed the required background screening pursuant to s. 400.215 or s. 408.809 within 90 days before applying for a certificate to practice and the person's background screening results are not retained in the clearinghouse created under s. 435.12, the board shall waive the requirement that the applicant successfully pass an additional background screening pursuant to s. 400.215. The person must also meet one of the following requirements:

(a) Has successfully completed an approved training program and achieved a minimum score, established by rule of the board, on the nursing assistant competency examination, which consists of a written portion and skills-demonstration portion approved by the board and administered at a site and by personnel approved by the department.

(b) Has achieved a minimum score, established by rule of the board, on the nursing assistant competency examination, which consists of a written portion and skills-demonstration portion, approved by the board and administered at a site and by personnel approved by the department and:

1. Has a high school diploma, or its equivalent; or
2. Is at least 18 years of age.

(c) Is currently certified in another state; is listed on that state's certified nursing assistant registry; and has not been found to have committed abuse, neglect, or exploitation in that state.

(d) Has completed the curriculum developed under the Enterprise Florida Jobs and Education Partnership Grant and achieved a minimum score, established by rule of the board, on the nursing assistant competency examination, which consists of a written

portion and skills-demonstration portion, approved by the board and administered at a site and by personnel approved by the department.

(2) If an applicant fails to pass the nursing assistant competency examination in three attempts, the applicant is not eligible for reexamination unless the applicant completes an approved training program.

(3) An oral examination shall be administered as a substitute for the written portion of the examination upon request. The oral examination shall be administered at a site and by personnel approved by the department.

(4) The board shall adopt rules to provide for the initial certification of certified nursing assistants.

(5) Certification as a nursing assistant, in accordance with this part, may be renewed until such time as the nursing assistant allows a period of 24 consecutive months to pass during which period the nursing assistant fails to perform any nursing-related services for monetary compensation. When a nursing assistant fails to perform any nursing-related services for monetary compensation for a period of 24 consecutive months, the nursing assistant must complete a new training and competency evaluation program or a new competency evaluation program.

(6) A certified nursing assistant shall maintain a current address with the board in accordance with s. 456.035.

(7) A certified nursing assistant shall complete 24 hours of inservice training during each biennium. The certified nursing assistant shall maintain documentation demonstrating compliance with this subsection.

(8) The department shall renew a certificate upon receipt of the renewal application and imposition of a fee of not less than $20 and not more than $50 biennially. The department shall adopt rules establishing a procedure for the biennial renewal of certificates. Any certificate that is not renewed by July 1, 2006, is void.

464.204 Denial, suspension, or revocation of certification; disciplinary actions

(1) The following acts constitute grounds for which the board may impose disciplinary sanctions as specified in subsection (2):

(a) Obtaining or attempting to obtain certification or an exemption, or possessing or attempting to possess certification or a letter of exemption, by bribery, misrepresentation, deceit, or through an error of the board.

(b) Intentionally violating any provision of this chapter, chapter 456, or the rules adopted by the board.

(2) When the board finds any person guilty of any of the grounds set forth in subsection (1), it may enter an order imposing one or more of the following penalties:

(a) Denial, suspension, or revocation of certification.

(b) Imposition of an administrative fine not to exceed $150 for each count or separate offense.

(c) Imposition of probation or restriction of certification, including conditions such as corrective actions as retraining or compliance with an approved treatment program for impaired practitioners.

(3) The board may, upon the request of a certificate holder, exempt the certificate holder from disqualification of employment in accordance with chapter 435 and issue a letter of exemption. The board must notify an applicant seeking an exemption from disqualification from certification or employment of its decision to approve or deny the request within 30 days after the date the board receives all required documentation.

464.205 Availability of disciplinary records and proceedings

Pursuant to s. 456.073, any complaint or record maintained by the department pursuant to the discipline of a certified nursing assistant and any proceeding held by the board to discipline a certified nursing assistant shall remain open and available to the public.

464.206 Exemption from liability

If an employer terminates or denies employment to a certified nursing assistant whose certification is inactive as shown on the certified nursing assistant registry or whose name appears on a criminal screening report of the Department of Law Enforcement, the employer is not civilly liable for such termination and a cause of action may not be brought against the employer for damages, regardless of whether the employee has filed for an exemption from the board under s. 464.204(3). There may not be any monetary liability on the part of, and a cause of action for damages may not arise against, any licensed facility, its governing board or members thereof, medical staff, disciplinary board, agents, investigators, witnesses, employees, or any other person for any action taken in good faith without intentional fraud in carrying out this section.

464.207 Penalties

It is a misdemeanor of the first degree, punishable as provided under s. 775.082 or s. 775.083, for any person, knowingly or intentionally, to fail to disclose, by false statement, misrepresentation, impersonation, or other fraudulent means, in any application for voluntary or paid employment or certification regulated under this part, a material fact used in making a determination as to such person's qualifications to be an employee or certificate holder.

464.208 Background screening information; rulemaking authority:

(1) The Agency for Health Care Administration shall allow the board to electronically access its background screening database and records.

(2) An employer, or an agent thereof, may not use criminal records or juvenile records relating to vulnerable adults for any purpose other than determining if the person meets the requirements of this part. Such records and information obtained by the board shall remain confidential and exempt from s. 119.07(1).

(3) If the requirements of the Omnibus Budget Reconciliation Act of 1987, as amended, for the certification of nursing assistants are in conflict with this part, the federal requirements shall prevail for those facilities certified to provide care under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act.

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Chapter 456
HEALTH PROFESSIONS AND OCCUPATIONS: GENERAL PROVISIONS

456.031 Requirement for instruction on domestic violence

(1)(a) The appropriate board shall require each person licensed or certified under chapter 458, chapter 459, part I of chapter 464, chapter 466, chapter 467, chapter 490, or chapter 491 to complete a 2-hour continuing education course, approved by the board, on domestic violence, as defined in s.741.28 as part of every third biennial relicensure or recertification. The course shall consist of information on the number of patients in that professional's practice who are likely to be victims of domestic violence and the number who are likely to be perpetrators of domestic violence, screening procedures for determining whether a patient has any history of being either a victim or a perpetrator of domestic violence, and instruction on how to provide such patients with information on, or how to refer such patients to, resources in the local community, such as domestic violence centers and other advocacy groups, that provide legal aid, shelter, victim counseling, batterer counseling, or child protection services.

(b) Each such licensee or certificate holder shall submit confirmation of having completed such course, on a form provided by the board, when submitting fees for every third biennial renewal.

(c) The board may approve additional equivalent courses that may be used to satisfy the requirements of paragraph (a). Each licensing board that requires a licensee to complete an educational course pursuant to this subsection may include the hour required for completion of the course in the total hours of continuing education required by law for such profession unless the continuing education requirements for such profession consist of fewer than 30 hours biennially.

(d) Any person holding two or more licenses subject to the provisions of this subsection shall be permitted to show proof of having taken one board-approved course on domestic violence, for purposes of relicensure or recertification for additional licenses.

(e) Failure to comply with the requirements of this subsection shall constitute grounds for disciplinary action under each respective practice act and under s. 456.072(1)(k). In addition to discipline by the board, the licensee shall be required to complete such course.

(2) Each board may adopt rules to carry out the provisions of this section.

456.033 Requirement for instruction for certain licensees on HIV and AIDS

The following requirements apply to each person licensed or certified under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 463; part I of chapter 464; chapter 465; chapter 466; part II, part III, part V, or part X of chapter 468; or chapter 486:

(1) Each person shall be required by the appropriate board to complete no later than upon first renewal a continuing educational course, approved by the board, on human immunodeficiency virus and acquired immune deficiency syndrome as part of biennial relicensure or recertification.

The course shall consist of education on the modes of transmission, infection control procedures, clinical management, and prevention of human immunodeficiency virus and acquired immune deficiency syndrome. Such course shall include information on current Florida law on acquired immune deficiency syndrome and its impact on testing, confidentiality of test results, treatment of patients, and any protocols and procedures applicable to human immunodeficiency virus counseling and testing, reporting, the offering of HIV testing to pregnant women, and partner notification issues pursuant to ss. 381.004 and 384.25.

(2) Each person shall submit confirmation of having completed the course required under subsection (1), on a form as provided by the board, when submitting fees for first renewal.

(3) The board shall have the authority to approve additional equivalent courses that may be used to satisfy the requirements in subsection (1). Each licensing board that requires a licensee to complete an educational course pursuant to this section may count the hours required for completion of the course included in the total continuing educational requirements as required by law.

(4) Any person holding two or more licenses subject to the provisions of this section shall be permitted to show proof of having taken one board-approved course on human immunodeficiency virus and acquired immune deficiency syndrome, for purposes of relicensure or recertification for additional licenses.

(5) Failure to comply with the above requirements shall constitute grounds for disciplinary action under each respective licensing chapter and s. 456.072(1)(e). In addition to discipline by the board, the licensee shall be required to complete the course.

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